Welcome to Sloan Optometry

Thank you for choosing Sloan Optometry for your eyecare needs. We are pleased to have you as a patient and appreciate the confidence you place in us. Please complete the following information. If you have any questions, please do not hesitate to ask.

Miss [ ] Mrs. [ ] Ms. [ ] Mr. [ ]   Male [ ] Female [ ]

First Name ______ Initial ______ Surname ______ Nickname ______

Street Address ______ City/State ______ Zip Code ______

Full Social Security ______ Date of Birth ______ Home Phone ______ Cell/Day Phone ______

Email Address ______ Guardian/Parent ______ Person Responsible for Account ______

Emergency Contact ______ Emergency Contacts Phone ______

Who referred you to our office? ______

PRIMARY INSURANCE

Name of Insurance ______ Insureds ID Number ______

Name of Insured ______ Insureds Date of Birth______

Insureds Social Security Number______

Relationship to Insured: Self [ ] Spouse [ ] Child [ ] Other [ ]

Patient Status: Single [ ] Married [ ] Other [ ]

Employed [ ] Student: FT [ ] PT [ ]

SECONDARY INSURANCE

Name of Insurance ______ Insureds ID Number ______

Name of Insured ______ Insureds Date of Birth______

Relationship to Insured: Self [ ] Spouse [ ] Child [ ] Other [ ]

Please read then sign:

All copays, deductibles, and professional fees not covered by insurance are due at time of service. I understand that I may receive a bill for any unmet deductible or co-insurance after my claim has been processed by my insurance company. I acknowledge that it is my responsibility to understand the benefits and limitations on benefits under my insurance or health plan and to contact my insurance carrier/health plan if I have any questions. I understand that insurance benefits are not a guarantee of payment by my insurance company and final determination can only be made when the claim is processed. I hereby authorize my insurance benefits be paid directly to Sloan Optometry. I understand that if my account is past due 90 days or more I will be sent to collections and charged an additional collections fee of $25. I understand that I will be charged an $25 fee for a Nonsufficient Funds check, in addition to the banking fees and chargebacks.

______ Signature ______ Date

PATIENT MEDICAL HISTORY AND INFORMATION

HEALTH HISTORY

What is the main reason for today's exam?____

When was your last eye exam?____________________ Date of last health exam? ________________________

Past Illnesses or Injuries:____

Past Eye Surgeries:____

Current Medications:____

Current Eye Drops: ____

Medicines that cause reactions or sensitivities:____

Allergies:____

EYE HISTORY CIRCLE Yes or No

Condition	Y	N
Glaucoma	Y	N
Cataracts	Y	N
Macular Degeneration	Y	N
Color Blindness	Y	N
Headaches	Y	N
Glare/Light Sensitivity	Y	N
Tired Eyes	Y	N
Amblyopia/Lazy Eye	Y	N
Burning	Y	N

Condition	Y	N
Dryness	Y	N
Watering/Tearing	Y	N
Sensation Foreign Body	Y	N
Eye or Lid Infection	Y	N
Itching	Y	N
Mucous/Discharge	Y	N
Drooping Eyelid	Y	N
Redness	Y	N
Sandy/Gritty Feeling	Y	N

Condition	Y	N
Strabismus	Y	N
Blurred Distance Vision	Y	N
Blurred Near Vision	Y	N
Distorted Vision/Halos	Y	N
Double Vision	Y	N
Floaters or Spots	Y	N
Fluctuating Vision	Y	N
Vision Loss	Y	N
Peripheral Vision Loss	Y	N

GENERAL HEALTH CONDITION

Condition	Y	N
Fever	Y	N
Weight Loss	Y	N
Other Symptoms	Y	N
Ear, Nose, Throat Issues	Y	N
Cardiovascular (BP)	Y	N

Condition	Y	N
Respiratory (Asthma)	Y	N
Gastrointestinal	Y	N
Kidney	Y	N
Muscles/Bones/Joints/Skin	Y	N
Neurological	Y	N

Condition	Y	N
Anxiety/Depression	Y	N
Thyroid, Diabetes	Y	N
Blood/Lymph	Y	N
Allergic	Y	N
Pregnant	Y	N
Nursing	Y	N

Any other symptoms / conditions ____

FAMILY HEALTH HISTORY

Condition	Y	N
Amblyopia/Lazy Eye	Y	N
Blindness	Y	N
Cataracts	Y	N
Color Blindness	Y	N
Glaucoma	Y	N
Macular Degeneration	Y	N

Condition	Y	N
Retinal Detachment	Y	N
Strabismus	Y	N
Arthritis	Y	N
Cancer	Y	N
Diabetes	Y	N
Heart Disease	Y	N

Condition	Y	N
High Blood Pressure	Y	N
Kidney Disease	Y	N
Lupus	Y	N
Stroke	Y	N
Thyroid Disease	Y	N
Other	Y	N

Any other diseases / conditions ____

PATIENT MEDICAL / EYECARE HISTORY QUESTIONAIRE

Occupation ______________________________ **How Long**________ **Employer**__________________________________

VISION CORRECTION BACKGROUND

Do you currently wear prescription glasses? Yes No Since what age? __________

Current Eyewear: Distance___ Bifocal ___ Progressive___ Sport___

Reading/Computer___ Trifocal___ Sunglasses___ Safety___

Do you use a computer? Yes No

- How many hours per day? _____
- Distance from computer screen: ______inches
- Number of screens at your desk? ____

Do you have vision problems with:

- Driving? Yes No
- Glare? Yes No
- Nighttime? Yes No

Have you had problems in the past with eyeglasses? Yes No (if "No", skip to next question)

If yes describe: ____

SPECIAL EYEWEAR NEEDS

Do you have any special eyewear needs (i.e. prescription goggles, motorcycle glasses, dental loops, etc)?

____

CONTACT LENS HISTORY

Are you interested in getting contact lenses? Yes No (if "No", skip to "Social History")

Have you ever worn contact lenses? Yes No

Do you currently wear contact lenses? Yes No If yes, since when? _________

Type/Brand/Prescription of contact lenses worn:____

SOCIAL HISTORY

Do you take any nutritional supplements (i.e. Omega 3's, Ocuvite/Preservision, Lutein, Vitamins, etc)?

____

Do you smoke? Yes No (if "No" skip to next question)

- Method of tobacco intake? Smoking___ Chewing___ Vaping____
- How often? Occasional ½ pk per day 1 pk per day 1+ pk per day

Do you use illegal drugs? Yes No

Hobbies / Interests____