Welcome to Sloan Optometry

Thank you for choosing us 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:

To control the cost of billing, we ask that the patient's portion is paid at the time services are rendered. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

I understand that payment from my insurance is to be paid directly to Sloan Optometry. I understand that it will be billed as my primary insurance. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

______ 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

Glaucoma	Y	N	Dryness	Y	N	Strabismus	Y	N
Cataracts	Y	N	Watering/Tearing	Y	N	Blurred Distance Vision	Y	N
Macular Degeneration	Y	N	Sensation Foreign Body	Y	N	Blurred Near Vision	Y	N
Color Blindness	Y	N	Eye or Lid Infection	Y	N	Distorted Vision/Halos	Y	N
Headaches	Y	N	Itching	Y	N	Double Vision	Y	N
Glare/Light Sensitivity	Y	N	Mucous/Discharge	Y	N	Floaters or Spots	Y	N
Tired Eyes	Y	N	Drooping Eyelid	Y	N	Fluctuating Vision	Y	N
Amblyopia/Lazy Eye	Y	N	Redness	Y	N	Vision Loss	Y	N
Burning	Y	N	Sandy/Gritty Feeling	Y	N	Peripheral Vision Loss	Y	N

GENERAL HEALTH CONDITION

Fever	Y	N	Respiratory (Asthma)	Y	N	Anxiety/Depression	Y	N
Weight Loss	Y	N	Gastrointestinal	Y	N	Thyroid, Diabetes	Y	N
Other Symptoms	Y	N	Kidney	Y	N	Blood/Lymph	Y	N
Ear, Nose, Throat Issues	Y	N	Muscles, Bones, Joints, Skin	Y	N	Allergic	Y	N
Cardiovascular (BP)	Y	N	Neurological)	Y	N	Pregnant	Y	N
						Nursing	Y	N

Any other symptoms / conditions ____

FAMILY HEALTH HISTORY

Amblyopia/Lazy Eye	Y	N	Retinal Detachment	Y	N	High Blood Pressure	Y	N
Blindness	Y	N	Strabismus	Y	N	Kidney Disease	Y	N
Cataracts	Y	N	Arthritis	Y	N	Lupus	Y	N
Color Blindness	Y	N	Cancer	Y	N	Stroke	Y	N
Glaucoma	Y	N	Diabetes	Y	N	Thyroid Disease	Y	N
Macular Degeneration	Y	N	Heart Disease	Y	N	Other	Y	N

Any other diseases / conditions ____

PATIENT MEDICAL / EYECARE HISTORY QUESTIONAIRE

Occupation ______________________________**Years**________ **Employer**__________________________________

VISION CORRECTION BACKGROUND

Do you use a computer? Yes No How many hours per day? _____ Distance from computer screen: ______inches

Do you drive? Yes No

Do you have problems with glare? Yes No

Do you have vision problems when driving? Yes No

Do you have problems with night vision? Yes No

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

Type of glasses: Full Time ___ Part Time ___ Distance ____ Near ___

Current Eyewear: Single Vision ___ Bifocal ___ Trifocal ___ Backup___ Safety ___ Sports ____ Progressives ____

Have you had trouble in the past with eyeglasses? Yes No

If yes describe: ____

Do you wear sunglasses? Yes No Prescription Sunglasses? Yes No

SPECIAL EYEWEAR NEEDS

Computer (dedicated computer Rx, anti-glare tints or coatings)

Safety Glasses (gardening, woodwork, welding)

Occupational (mechanics, shop, pilots)

Sports / Motorcycle (group participation sports)

CONTACT LENS HISTORY

If not a contact lens wearer, are you interested in trying contacts at this time? Yes No

Have you ever worn contact lenses? Yes No

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

Type/Brand of contact lenses worn: ____

SOCIAL HISTORY

Do you use nutritional supplements? Yes No

Do you engage in regular exercise? Yes No

Do you drink alcohol? Yes No If yes, how often? 1 per day 2-3 per day 4+ per day

Do you smoke? Yes No If yes, how often? Occasional ½ pk per day 1 pk per day 1+ pk per day

Method of tobacco intake: Smoking______ Chewing______ Vaping______

Do you use illegal drugs? Yes No

Hobbies / Interests____