

**WELCOME BACK TO OUR OFFICE**

Today's Date \_\_\_\_\_

**Patient Information**

Last \_\_\_\_\_  
 First \_\_\_\_\_ MI \_\_\_\_\_  
 Street \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_  
 Zip Code \_\_\_\_\_  
 Home Phone \_\_\_\_\_  
 Work Phone \_\_\_\_\_  
 Cell Phone \_\_\_\_\_  
 Patient's SSN \_\_\_\_\_  
 Employer (or School) \_\_\_\_\_  
 Occupation (or Grade) \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
 Sex M F  
 Email Address \_\_\_\_\_  
 Spouse (or Parent's Name) \_\_\_\_\_  
 Spouse (or Parent's Work) \_\_\_\_\_  
 What is the major purpose of this visit?  
 \_\_\_\_\_  
 \_\_\_\_\_

Any problems with your current contact lenses or glasses?  
 \_\_\_\_\_  
 \_\_\_\_\_

*The mission of Advance Eye Care of Chino is to contribute to a lifetime of healthy vision, proving each patient with the highest quality vision care and consequent quality of life. We will seek continuing education to remain at the forefront of our profession and will offer the latest eye care technology, professional services, and products. Our goal is to restore, maintain and enhance the vision of our patients. Everything we do shall communicate this.*

**Insurance Information**

Vision Insurance \_\_\_\_\_  
 Subscriber Name \_\_\_\_\_  
 Subscriber SSN/ID \_\_\_\_\_  
 Subscriber Birth Date \_\_\_\_\_  
 Primary Medical Insurance \_\_\_\_\_  
 Subscriber Name \_\_\_\_\_  
 Subscriber SSN/ID \_\_\_\_\_  
 Subscriber Birth Date \_\_\_\_\_

Do you participate in a flex spending account?

Yes  No

How will you settle your account today?

Cash  Check  Credit Card

**Lifestyle Questions**

**Do you.....(check box if your answer is yes)**

- ..work at a computer
- ..think you might benefit from thinner, lighter lenses?
- ..have interest in a "test drive" of the latest contact lens designs
- ..spend time outdoors? How much? \_\_\_Hrs/week
- ..have prescription sunwear?
- ..prefer not to wear your glasses at times?
- ..want information on Laser Vision Correction surgery?
- ..have interest in a non-surgical approach to vision correction?
- ..have more than 1 pair of current Rx eyewear?
- ..have children?
- ..have family members in need of eyecare?
- ..hobbies? If so what are they \_\_\_\_\_

**Have you ever experienced, been diagnosed or treated for any of the following?**

- |  |  |
|--|--|
| <input type="checkbox"/> Blurry Vision         | <input type="checkbox"/> Burning                 |
| <input type="checkbox"/> Cataracts             | <input type="checkbox"/> Corneal Abrasions       |
| <input type="checkbox"/> Crossed eye/Eye turn  | <input type="checkbox"/> Double Vision           |
| <input type="checkbox"/> Eye Infections        | <input type="checkbox"/> Eye Injury              |
| <input type="checkbox"/> Flash of light        | <input type="checkbox"/> Floaters/Spots          |
| <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Grittiness              |
| <input type="checkbox"/> Headaches             | <input type="checkbox"/> Iritis/Uveitis          |
| <input type="checkbox"/> Itchiness             | <input type="checkbox"/> Lazy Eye                |
| <input type="checkbox"/> Macular Degeneration  | <input type="checkbox"/> Occasional dryness      |
| <input type="checkbox"/> Retinal Detachment    | <input type="checkbox"/> Sunlight Sensitivity    |
| <input type="checkbox"/> Tearing               | <input type="checkbox"/> Trouble seeing at night |
| <input type="checkbox"/> Uncomfortable glasses | <input type="checkbox"/> Keratoconus             |
| <input type="checkbox"/> Tired or sore eyes    | <input type="checkbox"/> Fluctuating Vision      |
| <input type="checkbox"/> Glare when driving    |  |

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History		
Name of Family Physician	_____	
Town	_____	
Date of Last Physical Check-up	_____	
<b>CURRENT MEDICATIONS (Rx or Over the Counter)</b> (List name of medications including eye drops, vitamins, & birth control pills)		
_____		
_____		
_____		
Allergies to medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If so, what medications?	_____	
_____		
Have you had any surgeries?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you use cigarettes/tobacco, alcohol, or other substances?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you been exposed to or infected with Gonorrhea, Hepatitis, HIV or Syphilis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Have you ever been diagnosed or treated for the following health problems?</b>		
	<b>Yes</b>	<b>No</b>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Blood/Lymph	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Digestive	<input type="checkbox"/>	<input type="checkbox"/>
Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>
Eczema/Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (Skin)	<input type="checkbox"/>	<input type="checkbox"/>
Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Bone	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Psychological	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
Sinus	<input type="checkbox"/>	<input type="checkbox"/>
Throat Infections	<input type="checkbox"/>	<input type="checkbox"/>

Patient Eye History	
Date of Last Eye Exam	_____
By Whom?	_____
Have you ever tried contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you currently wear contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What kind?	_____
Solutions used	_____
Are you satisfied with the vision and comfort of your contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Would you prefer clear contact lenses or colored contact lenses?	<input type="checkbox"/> Clear <input type="checkbox"/> Colored
If you wear bifocals, do the lines or head tilting bother you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Family Medical/Eye History (Check all that apply)	
Is there a family medical history of any of the following:	
<input type="checkbox"/> No	<input type="checkbox"/> Yes (Please check boxes)
	Relationship (Mother's or Father's side)
Blindness	<input type="checkbox"/> _____
Cataracts	<input type="checkbox"/> _____
Corneal Problems	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/> _____
Glaucoma	<input type="checkbox"/> _____
Heart Disease	<input type="checkbox"/> _____
Lazy Eye	<input type="checkbox"/> _____
Macular Degeneration	<input type="checkbox"/> _____
Retinal Problems	<input type="checkbox"/> _____

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not Dr. Daniel Paul O.D. Inc. I hereby authorized my insurance benefits to be paid directly to Dr. Daniel Paul OD Inc. I authorize the use of this signature on all insurance submission. I grant permission to contact my physician and/or school to assist in my care.

Signature \_\_\_\_\_