Date_____

LONGMEADOW EYE CARE

WELCOME TO OUR OFFICE

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

Patient Information

Last Name _____

First Name _____ MI _____

Name Used / Nickname _____

Sex: ☐ Male ☐ Female

Race (if multicultural, list races)_____

_____

Date of Birth _____ Age _____

PO Box_____

Street Address_____

City_____

State_____ Zip_____

Home Phone _____

Cell Phone _____

Work Phone _____

Email Address _____

Patient's SSN _____

Employer (or school)_____

Business/School Address _____

_____

Occupation_____

Student ☐ Full Time ☐ Part Time ☐ Not Applicable

Driver's License #_____

Marital Status ☐ Single ☐ Married ☐ Divorced
☐ Widow ☐ Legally Separated

Insurance Information

Please note that most insurances do NOT cover the Contact Lens Fitting or Evaluation

Vision Insurance _____

Subscriber Name _____

Subscriber ID#_____

Subscriber Birth Date_____

Primary Medical Insurance _____

Subscriber Name _____

Subscriber ID#_____

Subscriber Birth Date_____

Secondary Medical Insurance_____

Subscriber Name _____

Subscriber ID#_____

Subscriber Birth Date_____

Medical Doctor

Medical Doctor_____

Address _____

_____

Phone_____

Fax _____

When was your last visit to your medical doctor?

_____

Do we need to send a report to this doctor regarding your examination with us? (e.g. diabetic eye report)

☐ Yes ☐ No

Patient Medical History

Have you ever been diagnosed or treated for the following health problems?

	Yes	No
Allergies	☐	☐
Arthritis	☐	☐
Blood/Lymph	☐	☐
Cancer	☐	☐
Cholesterol	☐	☐
Diabetes	☐	☐
Digestive Disorders	☐	☐
Ears/Nose/Throat	☐	☐
Endocrine	☐	☐
Eczema/Rashes	☐	☐
Fatigue	☐	☐
Genitourinary	☐	☐
Heart	☐	☐
High Blood Pressure	☐	☐
HIV	☐	☐
Integumentary (Skin)	☐	☐
Kidney	☐	☐
Muscle/Bone	☐	☐
Neurological	☐	☐
Psychological	☐	☐
Respiratory	☐	☐
Migraine/Headache	☐	☐
Thyroid Disease	☐	☐
Unusual weight loss/gain	☐	☐

Reason for Today's Visit (check all that apply):

☐ Treatment of Eye Disease ☐ Updating Glasses
☐ Emergency Office Visit ☐ Contact Lenses
☐ Referred by Physician ☐ Other

Patient Medical History

Have you or a blood relative ever been diagnosed or treated for the following health problems?

	Yes	No	Self	Family
Cataracts	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐
Floaters/Spots	☐	☐	☐	☐
Lazy Eye (Amblyopia)	☐	☐	☐	☐
Crossed Eyes	☐	☐	☐	☐
Eye Injury	☐	☐	☐	☐
Eye Surgery	☐	☐	☐	☐
Retinal Disease	☐	☐	☐	☐
Color Blindness	☐	☐	☐	☐
Vision Loss	☐	☐	☐	☐
Other Eye Problems	☐	☐	☐	☐

Date of last eye exam _____

By whom?_____

☐ I have never worn glasses

☐ Glasses worn: ☐ Full time ☐ Distance ☐ Near

Contact Lens History

Have you ever tried contact lenses? ☐ Yes ☐ No

Do you currently wear contact lenses? ☐ Yes ☐ No

Contact Lenses: ☐ Daily Wear ☐ Extended Wear
☐ Distance only ☐ Monovision ☐ Bifocal

What kind?_____

Solutions used _____

How often are you supposed to replace your contacts?_____

How old are the current contact lenses that you are wearing?_____

How many hours each day do you usually wear your contact lenses?_____

Are you satisfied with the vision and comfort of your contact lenses? ☐ Yes ☐ No

Would you prefer clear contact lenses or colored contact lenses? ☐ Clear ☐ Colored:_____

Social History

Tobacco Use

☐ Never ☐ Age Began_____

☐ Cigarettes Discontinued (list year) _____

☐ Cigarettes (approximate packs per week)_____

☐ Cigars (approximate number per week)_____

☐ Pipe (approximate number per week)_____

☐ Chewing Tobacco (approximate cans per week) _____

Drug Use (list frequency of use)

☐ Never

☐ Discontinued (list drug and year discontinued)

_____

☐ Cocaine_____

☐ Crack_____

☐ Heroin _____

☐ Marijuana_____

☐ Methamphetamine_____

☐ Speed _____

Alcohol (check type and number of drinks per week)

☐ Never

☐ Discontinued (list year discontinued)_____

☐ Beer _____

☐ Liquor_____

☐ Wine_____

Occupation_____

Hobbies_____

Lifestyle Questions

Do you work at a computer? ☐ Yes ☐ No
If yes, how many hours a day?_____

Do you think you might benefit from thinner, lighter lenses? ☐ Yes ☐ No

Do you spend time outdoors? ☐ Yes ☐ No
If yes, how many hours per week?_____

Do you have prescription sunwear? ☐ Yes ☐ No
Do you prefer not to wear glasses at times? ☐ Yes ☐ No

Do you have more than 1 pair of current Rx eyewear?
☐ Yes ☐ No

Do you have family members in need of eyecare?
☐ Yes ☐ No

Do you participate in any sports? ☐ Yes ☐ No
Do you have a home workshop? ☐ Yes ☐ No

LONGMEADOW EYE CARE

1545 Potomac Avenue, Hagerstown, MD 21742-2930
301-797-3030

Patient Name_____ Date_____

Medications

In order to keep your health safe, your Doctor needs to know ALL prescription, over-the-counter medications, vitamins, and herbal and nutritional supplements that you are taking. This also includes eye drops and ointments. Please be sure to fill in this information completely.

☐ Check if no medications are taken of any kind

Name of Medication	**Prescribed By (Name of Physician)**	**Dosage of Medication** (micrograms, milligrams, etc.)	**Form** (tablet, syrup, spray, injectable, inhaler, cream, eye drop, eye ointment, etc.)	**Taken How** (mouth, nasal, ocular, etc.)	**How Many and Taken How Often** (e.g. 1 pill 2 times daily; 2 pills 1 time daily; as needed; etc.)	**Use/ Reason for Taking** (high blood pressure, diabetes, etc.)

FOR OFFICE USE ONLY: Reviewed by:_____ Date_____

Doctor Signature_____ Date_____

Allergy

☐ Check if no known drug or environmental allergies of any kind

Allergy List Medication or Allergen (Penicillin, pollen, bees, shellfish, etc.)	**Type** (drug, environmental, insect, food, etc.)	**Onset** (list year, season, etc.)	**Reaction** (hives, anaphylactic shock, nausea, anxiety, etc.)	**Severity** (mild, moderate, severe)

Financial Policy

☐ I understand that I am responsible for payment of services rendered and any materials provided.
☐ Balances older than 30 days may be subject to additional collection fees, service charge fees, late fees, and/or interest charges of 2% per month; an annual percentage rate of 24%.
☐ Returned checks will carry an additional $35 charge to the patient's account balance.
☐ Referrals/Disputes: If a referral from your primary care clinic is required, and you choose to be seen without the necessary referral, you agree to be responsible for the charges incurred.
☐ I am also aware and do agree that if for any reason my account is assigned to a collection agency, I will be responsible for any and all collection fees that this office incurs in the collection of fees.

Patient, Parent or Guardian Signature:

_____ Date_____

Assignment of Benefits

We file insurance claims as a courtesy for our patients. Eligibility will be checked prior to your appointment. Your deductible and/or co-payment is expected at time of service. If the claim is denied, the remaining balance is your responsibility. If for any reason you dispute the payments made by your insurance company, it is your responsibility to contact the insurance company.

☐ I authorize use of this form on all my insurance submissions.
☐ I authorize release of information to all my Insurance Companies.
☐ I understand that I am responsible for my bill.
☐ I authorize my doctor to act as my agent in helping me obtain payment from my Insurance Companies.
☐ I authorize payment directly to my doctor.

Name (please print) _____

Signature_____ Date_____