Welcome to Nora Eye Care. Please take a moment to complete the following information. This form helps to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

□ Mr. □ Miss □ Mrs. □ Ms. □ Male □ Female

First Name MI Last Name Preferred Name

Street Address City State Zip Code

Social Security Number Date of Birth Home Phone – include area code Alternative Phone

Email Address Spouse or Parent (s) Name Person Responsible for Account

Emergency Contact Emergency Phone Height (feet / inches) Weight (pounds)

Race: □ American Indian/ Alaska Native □ Asian □ Black/ African American □ White □ Native American
□ Caucasian □ Native Hawaiian / Other Pacific Islander □ Hispanic / Latino □ Other _____ □ Refuse to Specify

How were you referred to our office?

□ Phone Book □ School □ Drive By □ Doctor (Please name) _____

□ Advertisement □ Insurance Listing □ Other_____ □ Patient (Please Name) _____

PRIMARY INSURANCE INFORMATION

Name and Address of Primary Insurance Company City State Zip Code

M □ F □ _____
Insured's First Name MI Insured's Last Name

Insured's Identification Number Group Number Insured's Date of Birth

Patient Relationship to Insured Patient Status □ Single □ Married □ Other

□ Self □ Spouse □ Child □ Other □ Full Time Student □ Part Time Student □ Employed

SECONDARY INSURANCE INFORMATION

Name and Address of Secondary Insurance Company City State Zip Code

M □ F □ _____
Insured's First Name MI Insured's Last Name

Insured's Identification Number Group Number Insured's Date of Birth Patient Relationship to Insured
□ Self □ Spouse □ Child □ Other

PLEASE READ:

In order to control the cost of billing, we ask the patient's portion is paid at the time of services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and materials 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.

Payment from my insurance is to be paid directly to Nora Eye Care. I understand that Nora Eye Care can bill my insurance as a courtesy. I understand billing my insurance is my responsibility. 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 Information Update

Primary Care Physician

_____

Primary Care Physician and Clinic Name

_____

Address of Primary Care Physician City State & Zip code Phone

Health History

What is the main reason for today's exam?_____When was your last eye exam?_____

When was your last health exam?_____

Past and **current illnesses or injuries** (examples: high blood pressure, GERD, Arthritis):

_____

_____

Past Surgeries, **since your last visit** (examples: Cataract, Lasik, hip, heart, knee):

_____

_____

Current Medications, Vitamins, and Supplements {including dosage amount, how often taken, and how administered (ie: pill, injection)}:

_____

_____

_____

_____

Current Eye Drops: _____

Medicines that cause reactions or sensitivities: _____

Specific Allergies (examples: hayfever, peanuts, pollen): _____

EYE HISTORY: DO YOU CURRENTLY HAVE ANY OF THESE CONDITIONS? PLEASE CIRCLE IF YOU DO.

Amblyopia
Blepharitis
Blindness
Cataract(s)
Color Blindness
Diabetic Retinopathy
Dry Eye Syndrome
Eye Injuries
Glaucoma
Glaucoma Suspect
Taking High Risk Medication
Macular Degeneration
PVD (Vitreous Detachment)
Retinal Detachment
Strabismus

Glare Sensitivity
Headaches
Light Sensitivity
Tired Eyes
Burning
Dryness
Excess Watering/ Tearing (Epiphora)
Eye Pain or Soreness
Foreign Body Sensation
Infection of Eye Lid
Itching
Mucous
Ptosis (Drooping Eye Lid)
Redness
Sandy or Gritty Feeling

Blurred Vision Distance
Blurred Vision Near
Distorted Vision
Double Vision
Flashes of Lights
Floaters or Spots
Fluctuating Vision
Loss of Central Vision
Loss of Side Vision
Loss of Vision
Other

EMAIL : _____
HEIGHT: _____
WEIGHT: _____

GENERAL HEALTH CONDITION: DO YOU HAVE ANY CONDITIONS OR ARE YOU TAKING ANY MEDICATIONS RELATING TO THE FOLLOWING? PLEASE CIRCLE IF YOU DO.

Fever
Weight Loss
Other Symptoms
Ears, Nose, Throat
Cardiovascular (high blood pressure, etc.)
Pregnant or Nursing

Respiratory (Asthma)
Gastrointestinal
Kidney
Muscles, Bones, Joints
Skin (acne, rosacea, etc.)

Neurological (Multiple Sclerosis)
Anxiety or Depression
Endocrine (Thyroid, Diabetes, etc.)
Blood/ Lymph (Cholesterol, anemia, etc.)
Allergic (hayfever, food, lupus, etc.)

FAMILY HISTORY: DOES OR DID ANYONE IN YOUR FAMILY HAVE ANY CONDITIONS RELATING TO THE FOLLOWING?

I.E. MOTHER, FATHER, GRANDPARENTS, SIBLINGS, AUNT, OR UNCLE **PLEASE CIRCLE IF SO AND LIST RELATIONSHIP**

Amblyopia (Lazy Eye)
Blindness
Cataracts
Color Blindness

Eye Tumors
Glaucoma
Glaucoma Suspect
Macular Degeneration

Retinal Detachment
Strabismus (Eye Turn)
Arthritis
Cancer

Diabetes
Heart Disease
High Blood Pressure
Kidney Disease

Lupus
Stroke
Thyroid Disease
Others

Patient Social and Eyewear Information Update

Please Circle Appropriate Answer

Current Occupation:_____ **Years**_____ **Employer**_____

Marital Status: SINGLE MARRIED SEPERATED DIVORCED WIDOWED

Do you drink alcohol? YES NO OCCASIONAL 1 PER DAY 2-3 PER DAY 4+ PER DAY

Do you smoke? NO OCCASIONAL ½ PACK PER DAY 1 PACK PER DAY 1+PACKS PER DAY

Past smoker? YES NO **When did you quit smoking?** _____

Smoking Status: CURRENT EVERY DAY SMOKER CURRENT SOME DAY SMOKER FORMER SMOKER NEVER SMOKER

Have you tried tobacco use cessation intervention, counseling? YES NO

Have you tried tobacco use cessation pharmacologic therapy? YES NO

Do you chew tobacco? YES NO **Do you use illegal drugs?** YES NO

Do you use nutritional supplements/ vitamins? YES NO **Do you engage in regular exercise?** YES NO

Do you use a computer? YES NO **Hours per day** _____ **Distance from computer** _____

Do you drive? YES NO **Daily Mileage** _____ **Do you have glare problems?** YES NO

Do you have visual difficulty when driving? YES NO **Do you have any problems with night vision?** YES NO

Do you currently wear glasses? YES NO **Since**_____ FULL TIME PART TIME DISTANCE NEAR

Glasses owned: SINGLE VISION SAFETY GLASSES BIFOCALS SPORTS GLASSES

TRIFOCALS PROGRESSIVE BACK-UP GLASSES OTHER

Have you had trouble in the past with glasses? YES NO **If yes, please explain**_____

_____

Do you wear sunglasses? YES NO **Are your sunglasses your current prescription?** YES NO

Special Eye Wear Needs: COMPUTER (SPECIAL PRESCRIPTIONS, SPECIAL ANTI-GLARE TINTS OR COATINGS

SAFETY GLASSES (GARDENING, WOODWORKING, WELDING)

OCCUPATIONAL (MECHANICS, PLUMBERS, PILOTS)

SPORTS/ HOBBIES (RACQUET SPORTS, MOTORCYCLE)

Hobbies/ Interests: _____

Have you tried to wear contact lenses? YES NO **Reason for stopping** _____

If not a contact lens wearer, are you interested in trying contact lenses at this time? YES NO

Do you currently wear contact lenses? YES NO **Since** _____

Type and brand of contact lenses _____ **Today's wearing time?** _____

How many hours per day do you wear contacts? _____ **How many days/ week?** _____

What contact lens solution do you use? Cleaner _____ **Disinfectant** _____ **Enzyme** _____

Please rate the following on a scale of 1-10, with 1 being POOR and 10 being EXCELLENT

Lens Comfort: RIGHT _____ LEFT_____ **Distance Vision:** RIGHT _____ LEFT_____ **Near Vision:** RIGHT _____ LEFT_____