Welcome to The Eye Site

Dr. Brett A. Dietz & Dr. Nancy R. Dietz

Date _____/_____/_____

Patient Information

Patient Name _____
Last First MI

Address _____ SSN_____

City _____ State_____ Zip _____Home Phone (____) _____

Gender ☐ M ☐ F Date of Birth _____/_____/_____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer or School _____ Work Phone (____) _____

Occupation or Grade _____ May we contact you at work if necessary ☐ Yes ☐ No

How did you hear about our practice?
☐ Insurance Provider ☐ Newspaper ☐ Phone Book ☐ Vision Screening ☐ Doctor Referral

☐ Referred by family or friends, whom may we thank _____

Insurance and Account Information

Insured Member or Person Responsible for Account _____
(If different from above) Last First MI

Date of Birth _____/_____/_____ SSN_____ Relation to Patient _____

Address _____City _____State _____ Zip _____

Employer _____ Phone (W) (____) _____(H) (____) _____

Primary vision insurance _____

Primary health insurance (if different) _____

For any secondary insurance, please ask for an itemized receipt to submit to your secondary carrier.

Payment of Exam Fees and/or Copays is required at the time of service. Please present your insurance card to the receptionist.

Please Note: If you do not have a current insurance card and we can not obtain authorization, today's fees must be paid in full. Some procedures, contact lens fees, materials, and medical eye problems may not be covered by insurance and are the responsibility of the patient. Please consult your insurance brochures regarding your deductibles and details about your coverage

I authorize the release of my medical information necessary to process this claim and I authorize payment of insurance benefits to The Eye Site. I also authorize my insurance company to review my record. I understand that in the event my insurance plan denies claims submitted by The Eye Site, payment of these services and/or materials would be my responsibility.

Signature _____*Date* _____

PLEASE CONTINUE

Patient Health History Information

How may we help you? Please briefly describe any problems with your eyes or vision.

_____

Is today's visit for: ☐ Glasses ☐ Contacts ☐ Medical Eye Problem ☐ Refractive Surgery Consultation
Do you currently wear: Glasses ☐ Yes ☐ No Sun Glasses ☐ Yes ☐ No Safety Glasses ☐ Yes ☐ No
If no, have you previously worn glasses? ☐ Yes ☐ No
Do you currently wear contact lenses? ☐ Yes ☐ No
If yes, please check type: ☐ Soft ☐ Gas Permeable
If no, have you previously worn contacts? ☐ Yes ☐ No
Do you use a computer? ☐ Yes ☐ No If yes, how many hours per day _____
Do your eyes feel tired, sore, dry, or become blurry at the computer? ☐ Yes ☐ No
Do you get headaches while working at the computer? ☐ Yes ☐ No

In which sports or hobbies activities do you participate? _____

Please indicate if you have any of the following eye symptoms:

☐ Flashes of Light	☐ Sudden Loss of Vision	☐ Glare at Night
☐ Floaters or Spots	☐ Dryness	☐ Sensitivity to Sunlight
☐ Double Vision	☐ Watery Eyes	☐ Other _____

Date of last eye exam (if not at our office) _____Location_____

Please indicate if you or family members have history of the following medical conditions:

	Self	Family		Self	Family		Self	Family
Cataracts	☐	☐	Headaches	☐	☐	Respiratory/Asthma	☐	☐
Glaucoma	☐	☐	Migraines	☐	☐	Allergies	☐	☐
Macular Degeneration	☐	☐	Diabetes	☐	☐	Skin Disorder	☐	☐
Retinal Detachment	☐	☐	High Blood Pres	☐	☐	Kidney Disease	☐	☐
Lazy Eye	☐	☐	Heart Disease	☐	☐	Inflammatory Diseases	☐	☐
Eye Surgery	☐	☐	Arthritis	☐	☐	Neurological	☐	☐
Refractive Eye Surgery	☐	☐	Thyroid	☐	☐	Blood Disorders	☐	☐
Blindness	☐	☐	Cancer	☐	☐	Head Injury	☐	☐

Other Medical Conditions/Pregnancy:_____

Have you had any type of eye injury? If yes, please explain _____

Please list all your current medications: _____

_____

Please list all medications you are allergic to: _____

Do you use: Tobacco Products ☐ Yes ☐ No Alcohol ☐ Yes ☐ No Recreational Drugs ☐ Yes ☐ No

Family Physician _____ Date of Last Exam_____

If completing this form for a minor, please sign below to authorize treatment:

_____ _____
Parent or Guardian Date