EyeCare Centers of CNY

"Professional vision care for the whole family"

General Information

* First Name:_____ * Last Name:_____ M.I.___ * Salutation:__Dr__Mr__Mrs__Ms. * Sex __M __F

* Spouse's Name:_____

* Street or P.O. Address:_____ * City:_____ * State:_____ * Zip:_____-_____

* Home Phone #:____-_____-_____ * Work Phone #:____-____-_____ * Cell Phone #:____-____-_____

May we contact you via text? _____

* Date of Birth:___/___/_____ * Age:____ Soc. Sec. #:_____ * Email Address:_____

May we contact you via email? _____

* Employer:_____ * Occupation:_____

If you were referred by an individual, would you like to tell us who it was?_____

Communication Preference: ❑ Email ❑ Postal ❑ Telephone Race/Ethnicity: _____

Insurance Information

PRIMARY INSURANCE INFO

* Insurance Company Name:_____

ID Number:_____

Name of Policy Holder:_____

Insured's Date of Birth:_____

Insured's Social Security #:_____

Patient's Relationship to Insured:_____

SECONDARY INSURANCE INFO

Insurance Company Name:_____

ID Number::_____

Name of Policy Holder:_____

Insured's Date of Birth:_____

Insured's Social Security #:_____

Patient's Relationship to Insured:_____

Responsible Party

Name of responsible person for this account _____

Relationship _____ DOB: _____ SS#: _____ Home Phone: _____

Address: _____

Employer: _____ Work Phone: _____

Eyeglass History

*** Do you wear glasses?**

- ❑ Never
- ❑ Full-Time
- ❑ Part-Time
- ❑ Distance Only
- ❑ Near Work Only

*** What type of glasses do you own?**

- ❑ Single Vision
- ❑ Progressive
- ❑ Bifocals
- ❑ Trifocals
- ❑ Safety Glasses
- ❑ Sports Glasses
- ❑ Backup Glasses
- ❑ Other
- ❑ None

*** Do you use a computer?**

- ❑ Yes
- ❑ No

If so, how many hours per day?

❑ 1-2 ❑ 2-4 ❑ 4-6 ❑ 6-8 ❑ 8+

How many inches are your eyes from your monitor?_____

	* Yes	No
Are you allergic to nickel?	◯	◯
If you wear eyeglasses, does your spare pair have your correct prescription?	◯	◯

Contact Lens History

	* Yes	No
Do you currently wear contact lenses?	◯	◯
Have you ever tried to wear contact lenses?	◯	◯
Are you interested in changing or enhancing your eye color?	◯	◯
If you currently wear contact lenses, do your backup eyeglasses have your correct prescription?	◯	◯
Are you having any problems with your current contacts?	◯	◯

Contact Lens History Cont'd

Answer the questions below ONLY IF you currently wear contact lenses:

What type or brand of contacts do you wear?_____

How old are your current lenses?_____

How often do you replace or dispose of your contact lenses?_____

What brand of solution do your lenses soak in overnight?_____

	Hours/Day	Days/Week
What is your typical contacts wearing schedule?		

	* Yes	No
Would you like to be evaluated for refractive laser surgery?	◯	◯
Would you like to be evaluated for a non-surgical method to correct your vision?	◯	◯

Medical History

* Date of Last Eye Exam:_____ * Where did you get your last eye exam?_____

* Date of Last Physical Exam:_____ * Name of Primary Care Physician:_____

*** Do you suffer from:**

	* Yes	No
Headaches?	◯	◯
Glare/Light Sensitivity?	◯	◯
Tired Eyes?	◯	◯
Amblyopia (lazy eye)?	◯	◯
Burning?	◯	◯
Dryness?	◯	◯
Epiphora (excess tearing)?	◯	◯
Eye Pain or Soreness?	◯	◯

	* Yes	No
Foreign Body Sensation?	◯	◯
Infection of Eye or Lid?	◯	◯
Itching?	◯	◯
Mucous Discharge?	◯	◯
Ptosis (drooping eyelid)?	◯	◯
Redness?	◯	◯
Sandy or Gritty Feeling?	◯	◯
Strabismus (crossed eyes)?	◯	◯

	* Yes	No
Blurred Distance Vision?	◯	◯
Blurred Near Vision?	◯	◯
Distorted Vision (haloes)?	◯	◯
Double Vision?	◯	◯
Floaters or Spots?	◯	◯
Fluctuating Vision?	◯	◯
Loss of Vision?	◯	◯
Loss of Side Vision?	◯	◯

Many diseases of the body have grave eye health consequences. While the questions below may seem unrelated to your eye health, it is crucial to your care that we ask them.

* Have you ever been treated for any MEDICAL CONDITIONS? (e.g., diabetes, high blood pressure, arthritis)

❑ Yes ❑ No If YES, please explain_____

* Have you ever had any EYE DISEASE? (e.g., glaucoma, cataracts, wandering or "lazy" eye, retinal detachment)

❑ Yes ❑ No If YES, please explain_____

* Have you ever had any SURGERY for your eyes or any other condition?

❑ Yes ❑ No If YES, please explain_____

* Do you take any MEDICATIONS?

❑ Yes ❑ No If YES, please explain_____

* Do you have any food or drug ALLERGIES?

❑ Yes ❑ No If YES, please explain_____

Medical History Cont'd

*** Do you currently have any of the following:**

	* Yes	No
Chronic fever / unexpected weight loss or gain / fatigue?	◯	◯
Ear/Nose/Throat problems (e.g., hearing loss, sinus problems, sore throat?)	◯	◯
Heart problems (e.g., chest pain, irregular heartbeat, swelling of feet, cold hands/feet?	◯	◯
Respiratory problems (e.g., shortness of breath, wheezing, coughing)?	◯	◯
Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea, vomiting)?	◯	◯
Genitournimary problems (e.g., painful urination, blood in urine, sex organ problems)?	◯	◯
Musculoskeletal problems (e.g., muscle aches, joint pain, swollen joints)?	◯	◯
Skin problems (e.g., rashes, excessive dryness, growths or lumps)?	◯	◯
Neurological problems (e.g., numbness, weakness, headaches, blackouts)?	◯	◯
Psychiatric problems (e.g., depression, anxiety)?	◯	◯
Endocrine problems (e.g., frequent urination, thirst, feeling hot or cold much of the time)?	◯	◯
Blood/Lymph problems (e.g., bruising, weakness, unusual paleness, swollen glands	◯	◯
Immune problems (e.g., frequent infections; allergic reactions to foods, dust, pollens)?	◯	◯

If you answered YES to any of these questions, please explain: _____

_____

_____

_____

Family/Social History

* Do you consume alcohol?
  - ❑ Never
  - ❑ Occasionally
  - ❑ 1 drink per day
  - ❑ 2-3 drinks per day
  - ❑ 4+ drinks per day

* Do you smoke?
  - ❑ Never
  - ❑ Occasionally
  - ❑ 1/2 pack per day
  - ❑ 1 pack per day
  - ❑ 1+ pack per day

* What is your Marital Status?
  - ❑ Single
  - ❑ Married
  - ❑ Other

**** Indicates Response Required***

Attention Contact Lens Patients:

Because the annual renewal of your contact lens prescription requires additional time and testing that is not included in the routine examination, an additional fee will be charged. This additional fee is $49. This fee does not include refitting to a different lens type. Refitting fees would then apply. If you are new to contacts, a new fit fee will be charged. You may choose to decline this evaluation. If you are coming in for yearly contact lens exam WITHOUT a routine eye exam, the fee will be $59.

_____I wish to have the contact lens evaluation today and agree to pay the fee of $49.
_____I wish to have the yearly contact lens exam today and agree to pay the fee of $59.
_____I decline the contact lens evaluation and understand that I cannot be provided with a prescription for contacts, or reorder new contacts at this time.

Signature_____**Date**_____

Retinal Imaging:

This procedure assists the doctor in early detection of eye diseases such as **glaucoma, diabetic retinopathy, and macular degeneration.** Eye changes from systemic medical problems such as **high blood pressure, malignant melanoma, and elevated cholesterol** are best monitored using this test.

Dr. Baker and Dr. Vinci strongly recommend that every patient have retinal imaging. It is especially important for those with **headaches, flashers, floaters, diabetes, glaucoma, or high blood pressure.**

There is an additional charge of **$45** for this procedure. If a medical diagnosis is made because of these procedures, then we can bill your medical carrier for them. **In most cases, insurance companies will NOT cover these tests when done routinely.**

_____**I DO want these tests performed** _____**I DO NOT want these tests performed.**

Signature_____**Date**_____