

Welcome to Brighton Eye Associates!

Mr. Dr. Last Name Ms. Mrs.	First Name & Middle Initial	Nickname	Date
Address	City	State & Zip	E-Mail Address
Place of Employment (Or School)	Type of Work (Or Grade)	Date of Birth & Age	Social Security Number
If Minor, Parent Name	Cell Phone	Home Telephone	Work Telephone May we contact you at work? Y / N

What is the major purpose of today's visit?

VERY IMPORTANT!
Whom may we thank for referring you to our office?

Name of friend or relative: _____
If not referred, how did you choose our office for your needs?
 Saw Sign / Building
 Insurance List
 Newspaper / Radio / TV / Yellow Pages
 Web Pages: Which web site? _____
 Other: _____

INSURANCE INFORMATION

Vision Insurance _____
 Subscriber Name _____
 Subscriber ID#/SSN _____
 Subscriber Birth Date _____

Primary Medical Insurance _____
 Subscriber Name _____
 Subscriber ID#/SSN _____
 Subscriber Birth Date _____

Do you participate in a flex spending account? Yes No
 How will you settle your account today? Cash Check Credit

Name of Family Physician / PCP _____
CURRENT MEDICATIONS (Rx or Over the Counter)
 (Please list names of medications including eye drops, vitamins,
 and birth control)

Emergency Contact _____
 Relationship _____
 Daytime Telephone / Cell Phone _____

PATIENT EYE HISTORY

Date of Last Eye Exam _____
 By Whom? _____

Have you ever worn contact lenses? Y N
 Do you currently wear contact lenses? Y N
 What kind? _____

Are you interested in contact lenses today? Y N
 Are you interested in ordering new glasses? Y N

Do you... (Check if you answer is Yes)
 Work at a computer? How much? _____ hrs/wk.
 Spend time outdoors? How much? _____ hrs/wk.
 Want information on refractive surgery?

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

<input type="checkbox"/> Cataracts	<input type="checkbox"/> Macular Degeneration
<input type="checkbox"/> Corneal Abrasion	<input type="checkbox"/> Retinal Detachment
<input type="checkbox"/> Eye Infection	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Eye Injury	<input type="checkbox"/> Iritis/Uveitis
<input type="checkbox"/> Lazy Eye	<input type="checkbox"/> Other _____

Do you experience or have you ever experienced?

<input type="checkbox"/> Floaters / spots	<input type="checkbox"/> Flash of Light
<input type="checkbox"/> Burning	<input type="checkbox"/> Grittiness
<input type="checkbox"/> Tearing	<input type="checkbox"/> Itchiness
<input type="checkbox"/> Headaches	<input type="checkbox"/> Crossed eye / eye turn
<input type="checkbox"/> Double Vision	<input type="checkbox"/> Trouble seeing at night
<input type="checkbox"/> Blurry Vision	<input type="checkbox"/> Bothered by Glare

(Distance / Near)

**Please see reverse side →

CASE HISTORY

Review of Systems	Name: _____	Date: / /
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Please mark the significant health history form below:

<p><u>Constitutional</u> <input type="checkbox"/> None</p> <p><input type="checkbox"/> Developmental disability</p> <p><input type="checkbox"/> Weight Loss</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> Trauma</p> <p><input type="checkbox"/> Other / Medications:</p> <p><u>Ears, Nose, Mouth & Throat</u> <input type="checkbox"/> None</p> <p><input type="checkbox"/> Upper respiratory tract infection</p> <p><input type="checkbox"/> Other / Medications:</p> <p><u>Cardiovascular</u> <input type="checkbox"/> None</p> <p><input type="checkbox"/> Heart disease</p> <p><input type="checkbox"/> Hypertension</p> <p><input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Vascular disease</p> <p><input type="checkbox"/> Other / Medications:</p> <p><u>Respiratory</u> <input type="checkbox"/> None</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Bronchitis</p> <p><input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> Other / Medications:</p>	<p><u>Gastrointestinal</u> <input type="checkbox"/> None</p> <p><input type="checkbox"/> Crohn's</p> <p><input type="checkbox"/> Colitis</p> <p><input type="checkbox"/> Ulcer</p> <p><input type="checkbox"/> Digestive</p> <p><input type="checkbox"/> Other / Medications:</p> <p><u>Genitourinary</u> <input type="checkbox"/> None</p> <p><input type="checkbox"/> Urinary tract infections</p> <p><input type="checkbox"/> Kidney ailments</p> <p><input type="checkbox"/> STD: Herpes, Chlamydia, HIV</p> <p><input type="checkbox"/> Other / Medications:</p> <p><u>Musculoskeletal</u> <input type="checkbox"/> None</p> <p><input type="checkbox"/> Fibromyalgia</p> <p><input type="checkbox"/> Muscular dystrophy</p> <p><input type="checkbox"/> Osteoarthritis</p> <p><input type="checkbox"/> Other / Medications:</p> <p><u>Integumentary</u> <input type="checkbox"/> None</p> <p><input type="checkbox"/> Eczema</p> <p><input type="checkbox"/> Rosacea</p> <p><input type="checkbox"/> Psoriasis</p> <p><input type="checkbox"/> Other / Medications:</p>	<p><u>Neurological</u> <input type="checkbox"/> None</p> <p><input type="checkbox"/> Multiple Sclerosis</p> <p><input type="checkbox"/> Epilepsy</p> <p><input type="checkbox"/> Other / Medications:</p> <p><u>Psychiatric</u> <input type="checkbox"/> None</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Panic disorder</p> <p><input type="checkbox"/> Schizophrenia</p> <p><input type="checkbox"/> Other / Medications:</p> <p><u>Endocrine</u> <input type="checkbox"/> None</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Thyroid dysfunction</p> <p><input type="checkbox"/> Hormonal dysfunction</p> <p><input type="checkbox"/> Other / Medications:</p> <p><u>Blood / Lymphatic</u> <input type="checkbox"/> None</p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Leukemia</p> <p><input type="checkbox"/> Other / Medications:</p> <p><u>Allergic / Immunologic</u> <input type="checkbox"/> None</p> <p><input type="checkbox"/> Drug allergy</p> <p><input type="checkbox"/> Environmental allergy</p> <p><input type="checkbox"/> Rheumatoid arthritis</p> <p><input type="checkbox"/> Lupus</p> <p><input type="checkbox"/> Other / Medications:</p>
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Social History

Do you use tobacco products? Yes No If yes, type / amount / how long: _____

Do you drink alcohol? Yes No If yes, type / amount / how long: _____

Do you use illegal drugs? Yes No If yes, type / amount / how long: _____

Have you ever been exposed to or infected with: Gonorrhea Syphilis HIV Hepatitis None

Family History

Is there any family medical history of any of the following? (If yes, please list the relationship to you). None

<input type="checkbox"/> Blindness _____	<input type="checkbox"/> Corneal Problems _____
<input type="checkbox"/> Cataracts _____	<input type="checkbox"/> Lazy Eye _____
<input type="checkbox"/> Glaucoma _____	<input type="checkbox"/> Diabetes _____
<input type="checkbox"/> Macular Degeneration _____	<input type="checkbox"/> Heart Disease _____
<input type="checkbox"/> Retinal Detachment _____	<input type="checkbox"/> Other Hereditary Diseases _____

Payment is Due at Time Services Are Rendered

For your health Safety, we perform annual contact lens evaluations. A separate contact lens fee, (starting at \$50.00), is charged beyond the comprehensive eye examination. Your doctor determines the fit, health and condition of the eyes with contact lenses. We also evaluate the changes in prescription and lens design during this process.

A Warning Regarding Eye Dilation

As part of each comprehensive eye examination, it is necessary to dilate the pupils of the eye. This may hinder your ability to see up close for 3-4 hours and may increase sensitivity to light.

Delinquent Accounts

I hereby authorize any necessary medical treatment by Dr. Kristen Banek in the practice of Brighton Eye Associates and agree to be responsible for my bill and any collection fees incurred by Brighton Eye Associates in attempt to collect payments of materials and/or services rendered. I authorize the office of Brighton Eye Associates to release or obtain any required medical information from my attending physicians or medical facility. I also authorize Brighton Eye Associates to file my insurance and collect payment on my behalf.

A Warning Regarding Pregnancy

If you are nursing, pregnant, or think you may be, please notify the staff and doctor prior to receiving any eye drops.

Signature _____ Date _____