Welcome to Advanced Eyecare & The Eyewear Gallery

We're glad you're here!

Today's Date:_____

Patient Information

Last_____
First_____MI_____
Preferred Name_____
Mailing Address_____
_____
Street Address_____
_____
City, State, Zip_____
Home Phone_____
Cell Phone_____
Work Phone_____
Date of Birth_____Age_____
Patient's SSN_____
Sex: M F Other_____
Employer_____
Occupation _____
Email Address_____
Spouse/Parent/Guardian's Name_____
S/P/G Employer _____

Social History

Prefered Language_____

Race: ____Caucasion ____Native American
____Asian ____Black / African Amera
____Hispanic ____HI / Pacific Islands

Ethnicity:__Hispanic/Latino ____HI/Pacific Islander
____Native American ____Asian
____Caucasian ____ Other

Lifestyle Questions

Place a check in the space provided if you…

_____ Work at a computer
_____ Think you might benefit from thinner lighter lenses
_____ Are interested in trying contact lenses
_____ Have prescription sunwear
_____ Prefer not to wear your glasses at times
_____ Want information on laser vision correction surgery
_____ Have interest in non-surgical vision correction
_____ Have Children
_____ Have family members interested in eye care

How did you hear about our office?

_____ Phone Book
_____ Social Media
_____ Internet Search
_____ Referral (Name)_____
_____ Other _____

Insurance Information

Primary Insurance_____
Subscriber Name_____
Subscriber SSN_____
Subscriber DOB_____
Mailing Address_____

Secondary Insurance_____
Subscriber Name_____
Subscriber SSN_____
Subscriber DOB _____
Mailing Address_____

Do you participate in a flex spending account? YES NO

How will you settle your account today?
CASH CHECK CREDIT CARD

What is the major purpose of this visit?

_____
_____
_____
_____
_____

Are you experiencing any problems with your current glasses or contact lenses?

_____
_____
_____

Insurance verification is a quote of benefit and not a guarantee of payment.

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company, NOT Advanced Eyecare.

Release of Benefits and Information

I authorize my insurance benefits, regardless of insurance coverage, to be paid directly to Lynn E. Goodwin, O.D., P.C.
I authorize Lynn E. Goodwin, O.D., P.C. or the insurance company to release any information required for this claim.
Even though an insurance claim is pending you will receive a statement each month if your account has an outstanding balance. We will be happy to file your insurance claim, however we cannot accept responsibility for collecting your insurance claim. The responsible party is obligated for payments in full to this account. In the event of non-payment, responsible party is obligated to payment in full on this account. In the event of non-payment, responsible party shall bear the cost of collection, and/or court costs and reasonable legal fees, should this be required.

Signature_____ **Date**_____

Patient Medical History

Primary Care Physician_____
Phone_____
Address _____
Date of last physical _____

Current Medications

Please include name and dosage of all medications

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Allergies to medications? YES NO

If so, what medications? _____
_____
_____

Have you had any surgeries? YES NO
Do you use Tobacco? YES NO
Do you use Alcohol? YES NO
Do you use drugs? YES NO

Family Medical Eye History

Is there a family medical history of any of the following?

Condition **Relationship to you**

Blindness _____
Cataracts _____
Corneal Problems _____
Diabetes _____
Glaucoma _____
Heart Disease _____
Lazy Eye _____
Macular Degeneration_____
Retinal Problems_____
Crossed Eyes _____

Patient Eye History

Date of last eye exam_____
By whom?_____
Do you currently have glasses? YES NO
Do you currently wear contacts? YES NO
Have you worn contacts in the past? YES NO

Have you ever experienced or been treated for any of the following ocular conditions? Please check all that apply.

____Blurry Vision ____Burning ____Cataracts
____Corneal Abrasions ____Crossed Eye ____Double Vision
____Eye Infections ____Eye Injury ____Flash of Light
____Floaters / Spots ____Glaucoma ____Grittiness
____Headaches ____Iritis/Uveitis ____Itchiness
____Macular Degeneration____Dry Eyes ____Retinal Detach
____Sunlight Sensitivity ____Tearing ___Poor Night Vision
____Other_____

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

	YES	NO
Aids / HIV	____	____
Allergies	____	____
Arthritis	____	____
Blood/Lymph	____	____
Bronchitis	____	____
Cancer	____	____
Cholesterol	____	____
Diabetes	____	____
Ears/Nose?Throat	____	____
Endocrine	____	____
Eczema/Rashes	____	____
Fatigue	____	____
Fevers	____	____
Genitourinary	____	____
High Blood Pressure	____	____
Integumentary (Skin)	____	____
Kidney	____	____
Muscle / Bone	____	____
Neurological	____	____
Psychological	____	____
Respiratory	____	____
Sinus	____	____
Throat Infections	____	____
Thyroid	____	____
Unusual weight loss or gains	____	____