SUMMIT EYECARE

Your vision is our focus!

Patient Information

Last Name: _____

First Name: _____ MI: _____

Patient DOB: _____

Race: _____ Ethnicity: _____

Patient's SSN: _____

Address: _____

City: _____ State: _____

Zip Code: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email Address: _____

Employer: _____

Occupation: _____

Spouse's or Parent's Name: _____

Spouse's or Parent's Employer: _____

Insurance Information

You are responsible for providing current, accurate insurance information in order for your insurance claim to be filed. We are happy to assist you in understanding your benefits.

Vision Insurance Provider: _____

Subscriber Name: _____

Subscriber ID: _____

Subscriber DOB: _____

Medical Insurance Provider: _____

Subscriber Name: _____

Subscriber ID: _____

Subscriber DOB: _____

Secondary Insurance Provider: _____

Subscriber Name: _____

Subscriber ID: _____

Subscriber DOB: _____

Lifestyle Questions

What is your preferred language? _____

Do you accept text messages? Y / N

Do you... (check all that apply)

- ☐ Work at a computer? How much? _____
- ☐ Have interest in thinner, lighter lenses?
- ☐ Spend time outdoors? How much? _____
- ☐ Have sunglasses?
- ☐ Prefer not to wear your glasses?
- ☐ Want information about LASIK?
- ☐ Have more than one pair of prescription glasses?
- ☐ Have children?
- ☐ Have family members in need of eyecare?

Do you... (please list frequency and type)

- ☐ Drive? _____
- ☐ Use tobacco products? _____
- ☐ Drink alcohol? _____
- ☐ Use recreational drugs? _____

The information you provide on this history form is critical to both the evaluation of your vision and health. Complete **BOTH** sides with total accuracy.

Patient Eye History

Date of Last Eye Exam: _____

Name of Doctor: _____

Do you wear? ☐ Glasses ☐ Contacts

Brand of Contacts? _____

Solution used? _____

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

- ☐ Blurred Vision
- ☐ Cataract
- ☐ Lazy Eye
- ☐ Eye Infections
- ☐ Light Flashes
- ☐ Glaucoma
- ☐ Headache
- ☐ Itchiness
- ☐ Dry Eye
- ☐ Tearing
- ☐ Vision Loss
- ☐ Discharge
- ☐ Stye or Chalazion
- ☐ Light Sensitivity
- ☐ Burning
- ☐ Corneal Abrasion
- ☐ Double Vision
- ☐ Eye Injury
- ☐ Floaters/Spots
- ☐ Grittiness
- ☐ Iritis/ Uveitis
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Poor Night Vision
- ☐ Eye Fatique
- ☐ Foreign Body Sensation
- ☐ Distortion/ Halos
- ☐ Redness

Patient Medical History

Primary Care Provider: _____

Date of Last Physical: _____

Current Medications (please list all prescriptions or over the counter medications you use, including eye drops, vitamins and birth control):

_____

_____

Allergies (including seasonal and medication allergies):

_____

_____

Have you experienced, been diagnosed with, or been treated for any of the following?

☐ Allergies	☐ Endocrine Disorder	☐ Constipation	☐ Multiple Sclerosis
☐ Cardiovascular Disease	☐ Crohn's Disease	☐ Genitourinary Disorder	☐ Brain Damage
☐ High Blood Pressure	☐ Thyroid Disorder	☐ Blood Disorder	☐ Epilepsy
☐ High Cholesterol	☐ Diabetes	☐ Anemia	☐ Psychiatric Disorder
☐ Stroke	☐ Hyploglycemia	☐ Skin Disorder	☐ Attention Disorder
☐ Heart Arrhythmia	☐ Pituitary Disorder	☐ Rosacea	☐ Depression
☐ Constitutional Disorder	☐ Renal Disease	☐ Eczema	☐ Autism
☐ Fever	☐ Gout	☐ Musculoskeletal Disorder	☐ Dementia
☐ Chills	☐ Gastrointestinal Disease	☐ Arthritis	☐ Respiratory Disease
☐ Weight Loss/Gain	☐ Nausea	☐ Muscle/Joint Pain	☐ Asthma
☐ Fatigue	☐ Vomiting	☐ Neurological Disorder	☐ Bronchitis
☐ Cancer	☐ Diarrhea	☐ Headache	☐ COPD/ Emphysema

Use the space below to explain any condition marked above or any unlisted conditions that you may have:

_____

_____

Surgeries (please list all systemic and ocular surgeries you have had:

_____

_____

Family Medical/ Eye History

Does a history of any of the following condition exist in your family (please list relationship)?

☐ Blindness _____	☐ Diabetes _____
☐ Cataracts _____	☐ Cardiovascular Disease _____
☐ Corneal Problems _____	☐ High Blood Pressure _____
☐ Glaucoma _____	☐ Kidney Disease _____
☐ Lazy Eye _____	☐ Lupus _____
☐ Macular Degeneration _____	☐ Thyroid Disease _____
☐ Retinal Problems _____	☐ Cancer _____
☐ Other: _____	☐ Arthritis _____

I affirm that the information I have provided on this patient history form is accurate to the best of my knowledge.

Signature: _____ Date: _____

Thank you very much for trusting Summit Eyecare with your eyecare needs. We

Which one of our locations did you visit today?

Idaho Falls/ Merlin	Idaho Falls/ Pancheri	Pocatello	St. Anthony	Rexburg

Were you referred by a patient of Summit Eyecare? Y or N

If yes, who may we thank for referring you? _____

Where have you learned about us? (Select all that apply)

- ☐ Google
- ☐ Facebook
- ☐ Website
- ☐ YouTube
- ☐ Building Sign
- ☐ Automobile Advertisement
- ☐ Other:

  Please explain: _____

Were you referred by your insurance company? Y or N

If referred by your insurance company, please let us know which insurance you have.

- ☐ Name:_____

Did you visit our website before calling us? Y or N

_____

_____

_____

_____