



Patient Information

Insurance Information

Last Name: _____ First Name: _____ MI: _____ Patient DOB: _____ M / F 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: _____	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

Patient Eye History

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? _____	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? <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">Blurred Vision</td> <td style="width: 50%;">Burning</td> </tr> <tr> <td>Cataract</td> <td>Corneal Abrasion</td> </tr> <tr> <td>Lazy Eye</td> <td>Double Vision</td> </tr> <tr> <td>Eye Infections</td> <td>Eye Injury</td> </tr> <tr> <td>Light Flashes</td> <td>Floaters/Spots</td> </tr> <tr> <td>Glaucoma</td> <td>Grittiness</td> </tr> <tr> <td>Headache</td> <td>Iritis/ Uveitis</td> </tr> <tr> <td>Itchiness</td> <td>Macular Degeneration</td> </tr> <tr> <td>Dry Eye</td> <td>Retinal Detachment</td> </tr> <tr> <td>Tearing</td> <td>Poor Night Vision</td> </tr> </table>	Blurred Vision	Burning	Cataract	Corneal Abrasion	Lazy Eye	Double Vision	Eye Infections	Eye Injury	Light Flashes	Floaters/Spots	Glaucoma	Grittiness	Headache	Iritis/ Uveitis	Itchiness	Macular Degeneration	Dry Eye	Retinal Detachment	Tearing	Poor Night Vision
Blurred Vision	Burning																				
Cataract	Corneal Abrasion																				
Lazy Eye	Double Vision																				
Eye Infections	Eye Injury																				
Light Flashes	Floaters/Spots																				
Glaucoma	Grittiness																				
Headache	Iritis/ Uveitis																				
Itchiness	Macular Degeneration																				
Dry Eye	Retinal Detachment																				
Tearing	Poor Night Vision																				

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.



Vision Loss

Discharge

Stye or Chalazion

Light Sensitivity

Eye Fatigue

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 latex or 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 (1 / 2 / Pre) | Anemia | Psychiatric Disorder |
| Stroke | Hypoglycemia | 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/Muscle/Joint Pain | Respiratory Disease |
| Weight Loss/Gain | Nausea | Pregnancy | 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 _____

Cataracts _____

Corneal Problems _____

Diabetes _____

Cardiovascular Disease _____

High Blood Pressure _____

Glaucoma _____

Lazy Eye _____

Macular Degeneration _____

Retinal Problems _____

Other: _____

Kidney Disease _____

Lupus _____

Thyroid Disease _____

Cancer _____

Arthritis _____

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

Signature: _____ Date: _____

Updated 6/2024



Thank you very much for trusting Summit Eyecare with your eyecare needs. We look forward to providing you with a great experience. Please take a moment to fill out where you have heard about us so that we can thank them for your visit.

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
