Date: _____/_____/_____

Title____Last Name ____________________ First Name ________________ MI ___

Address ____ Apt ________

City ______________________________________ State _______ Zip ___________

Date of Birth _____/_____/_____ Age ______ Gender ☐ Male ☐ Female

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

E-mail address ____

☐ Home Phone ( ) ______________________
☐ Work Phone ( ) ______________________
☐ Cell Phone ( ) ______________________

Which number should we use to reach you? Please place a check (X) beside the number you prefer

Patient's Occupation___________________ Patient's Employer_________________

Spouse's or Partner's Name ____

Parent's Names: (if patient is a child) Mother ____________________________________

Father ____________________________________

Has anyone in your family been seen here before? ☐ Yes ☐ No

If yes, name of family member ____

How did you choose our office? ☐ Friend _________________(who may we thank?)
☐ LensCrafters website ☐ Yellow Pages ☐ Insurance ________________
☐ LensCrafters associate ☐ Other ____________________________

INSURANCE INFORMATION

PRIMARY MEDICAL INSURANCE __________________________Policy #______________

SECONDARY INSURANCE ______________________________Policy # ______________

VISION CARE INSURANCE _____________________________Policy # ______________

By signing below, I give my authorization to Dr. Tamara L. Maule & Associates to provide medical treatment. I authorize the release of medical information necessary to process any insurance claims on my behalf, and I request that payment of authorized insurance benefits be made on my behalf to Dr. Tamara L. Maule & Associates. I authorize the use of this signature on all my insurance submissions. I understand that I am ultimately responsible for payment of my bill, and that a statement will be sent to me for any covered balance that is not paid by insurance.

____
Signature of Patient (or guardian if patient is a minor) Date

____
Printed Name of Patient (or guardian) Relationship to Patient

What is the reason for today's visit? ______________________________

Date of last eye examination__________________Location of last eye examination______________________

Do you currently wear eyeglasses? Yes ❑ No ❑ Age of present glasses ______________________

Have you had any eye injuries, eye diseases or eye surgery in the past? Yes ❑ No ❑

If yes, please describe: ______________________________

Is there anything that is bothering you today regarding your eyes or vision? ______________________

What sports or hobbies do you participate in? ______________________________

Are you interested in information about reducing/eliminating your need for glasses or contacts? Yes ❑ No ❑

Do you currently wear contact lenses? Yes ❑ No ❑

What type? gas permeable ❑ soft disposable ❑ toric ❑ monovision ❑ bifocal ❑

How old is your current pair of contact lenses? ______________________

How often do you replace your lenses? every day ❑ every week ❑ every 2 weeks ❑every month ❑other_____

What brand of solutions do you use to disinfect/store your lenses? ______________________

Are you having any problems with your contact lenses? Yes ❑ No ❑ ______________________

Do you have a pair of backup eyeglasses with your correct prescription? Yes ❑ No ❑

Many diseases of the body can have serious eye health consequences. For example, diabetes is one of the leading causes of blindness. Therefore, it is imperative we acquire an in depth medical history. Please answer the following questions. While they may seem unrelated to an eye problem, it is crucial to your care that we ask them.

Please list all the medications you are taking: ______________________________

Please list any allergies (seasonal or medical): ______________________________

Dou you currently have, or have you ever had, any problems in the following areas?

	YES	NO
Constitutional		
Fever/ Weight change	❑	❑
Skin	❑	❑
Neurologic		
Headaches/Migraines	❑	❑
Seizures	❑	❑
Cardiovascular		
Diabetes	❑	❑
Heart Disease	❑	❑
High Blood Pressure	❑	❑
Stroke	❑	❑
High Cholesterol	❑	❑
Genitourinary		
Kidney Disease	❑	❑
Painful/frequent urination	❑	❑
Lymphatic		
Anemia	❑	❑
Bleeding Problems	❑	❑
Allergic/Immunologic	❑	❑

	YES	NO
Ears, Nose, Mouth, Throat		
Allergies/Hay Fever	❑	❑
Sinus problems	❑	❑
Chronic cough	❑	❑
Dry Mouth/Throat	❑	❑
Respiratory		
Asthma	❑	❑
Chronic Bronchitis	❑	❑
Emphysema	❑	❑
Gastrointestinal		
Diarrhea	❑	❑
Constipation	❑	❑
Colitis/IBS	❑	❑
Ulcers/hernias	❑	❑
Bones/Joints/Muscles		
Arthritis	❑	❑
Joint Pain	❑	❑
Muscle Pain	❑	❑
Endocrine		
Hyperthyroid	❑	❑
Hypothyroid	❑	❑

Do you have any other conditions not listed above? Yes ❑ No ❑ ______________________

Do any of your blood relatives (parents / siblings) have a history of:

	YES	NO
Glaucoma	❑	❑
Retinal detachment	❑	❑
Amblyopia/Strabismus	❑	❑
Macular degeneration	❑	❑

	YES	NO
High blood pressure	❑	❑
Diabetes	❑	❑
Heart disease	❑	❑

***The following information is kept strictly confidential as part of your protected medical record. However, you may discuss this portion directly with the doctor if you prefer. ❑ Yes, I would prefer to discuss my social history directly with the doctor.

Do you use tobacco products?	❑	❑	type/amount/how long? ______________________
Do you drink alcohol?	❑	❑	type/amount/how often? ______________________
Do you use illegal drugs?	❑	❑	type/amount/how often? ______________________

Please check if you have ever been exposed to or infected with:

❑ HIV ❑ Hepatitis ❑ Tuberculosis ❑ any STD (chlamydia, gonorrhea, syphilis)