Helfrich Family Eye Care

Name: _____

Address: _____

City, St: _____ **Zip:** _____

Phone(H): _____ **(Cell):** _____

Birthday: _____ **Sex:** _____

E-Mail: _____

(please print)

Insurance: _____ **Number:** _____

Name of Insured: _____ **Rel:** _____

Secondary: _____ **Number:** _____

Name of Insured-2: _____ **Rel:** _____

Medical Doctor(s): _____

Phone: <Field Missing>

Have you ever worn

☐ No ☐ Glasses ☐ Gas Perm
☐ Bifocals ☐ Hard
☐ Trifocals ☐ Monovision
☐ No- line ☐ Disposable
☐ Soft Contacts ☐ Overnight wear
☐ Toric Soft

Approx. Date of Last Eye Exam:

_____

Occupation: _____

Employer: _____

Medications (including oral contraceptives, aspirin, over the counter medications and remedies)

☐ No

Have your had your flu shot this year?: ◯ Yes ◯ No

Our office requires payment at the time of service unless we "accept assignment" on your insurance. **You are responsible if your insurance does not pay. Contact lens fittings are billed separately from your eye exam.** I authorize the release of any medical or other information necessary to process this claim. I also request payment of insurance benefits to the party who accepts assignment below. Your information is protected by our privacy policy.
I have received a copy of Helfrich Family Eye Care "Notice of Privacy Practices".

Signature: _____ **Date:** _____

Social History

☐ Computer ☐ Golf ☐ Drug Abuse
☐ Reading ☐ Fishing ☐ Alcohol Abuse
☐ Student ☐ Tennis ☐ No alcohol or drug abuse
☐ Music ☐ Swim ☐ Other...
☐ Skiing ☐ Bike

Family History (parents, grandparents, siblings)

☐ Blindness ☐ Kidney Disease ☐ High B.P. ☐ Other...
☐ Cataracts ☐ Macular Degen. ☐ Thyroid
☐ Crossed Eyes ☐ Retina Disease ☐ Glaucoma
☐ Color Blind ☐ Retina Detach ☐ Cancer
☐ Diabetes ☐ Heart Disease ☐ None

Medical History

Do you currently, or have you ever had problems in the following areas:

Constitutional: ☐ No ☐ Fever, Weight Loss/Gain ☐ Pregnant/Nursing
Integumentary: ☐ No ☐ Skin
Neurological: ☐ No ☐ Headaches ☐ Migranes ☐ Seizures
Endocrine: ☐ No ☐ Thyroid ☐ Other Glands
Ears, Nose, Throat, Mouth: ☐ No ☐ Allegies/ Hay Fever ☐ Post-Nasal Drip ☐ Sinus Congestion ☐ Chronic Cough ☐ Runny Nose ☐ Dry Throat/ Mouth
Respiratory: ☐ No ☐ Asthma ☐ Bronchitis ☐ Emphysema
Vascular, Cardiac: ☐ No ☐ Diabetes ☐ High Blood Pressure ☐ Heart ☐ Vascular Disease
Gastrointestinal: ☐ No ☐ Diarrhea ☐ Constipation
Genitourinary: ☐ No ☐ Genitals/ Kidney/ Bladder
Musculoskeletal: ☐ No ☐ Arthritis ☐ Muscle Pain
Lymph/Hematologic: ☐ No ☐ Anemia ☐ Bleeding Problems
Psychiatric: ☐ No ☐ Psychiatric
Allergies: ☐ No ☐ Penicillin ☐ Eye drops ☐ Codeine ☐ Sulfa ☐ Novocain

Cancer: ☐ No If Yes, Type of Cancer_____

Other:

Eyes

☐ Loss of Vision ☐ Eye Pain or Soreness ☐ Other...
☐ Blurred Vision ☐ Chronic Eye Infection
☐ Distorted Vision/Halos ☐ Sties or Chalazion
☐ Loss of Side Vision ☐ Flashes/ Floaters
☐ Double Vision ☐ Tired Eyes
☐ Dryness ☐ Crossed Eyes
☐ Mucous Discharge ☐ Lazy Eye
☐ Redness ☐ Drooping Eyelid
☐ Sandy or Gritty Feeling ☐ Prominent Eyes
☐ Itching ☐ Glaucoma
☐ Burning ☐ Retinal Disease
☐ Foreign Body Sensation ☐ Cataracts
☐ Excess Tearing/ Watering ☐ Eye Infections
☐ Glare/ Light Sensitivity ☐ Eye Injury

Office Use:

Specs

Cl

Color

Lasik

Injuries / Surgeries /Hospitalizations Other

☐ No Surgeries, injuries, or hospitalizations
☐ LASIK Surg.
☐ Cataract Surg.
☐ Heart Surg.

For Office Use Only: _____ **Check In** _____ **Forms Returned** _____ **Start Pre-Test** _____ **End Pre-Test** _____ Check Out