Ackerson EyeCare Inc
Welcome Back To Our Office

Welcome to Ackerson EyeCare Inc. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name ______ MI ______ Last Name ______ Preferred Name ______

Street Address ______ City ______ State Zip ______

Date of Birth ______ Home Phone - Include Area Code ______ Work Phone ______

Email Address ______ Person Responsible for Account ______

Height ft ___ in ___ cm/m ___ (◉ ft in ○ cm ○ m)

Weight ___ (◉ lbs ○ kg)

☐ American Indian Or Alaska Native
☐ Asian
☐ Black Or African American
☐ Native Hawaiian Or Other Pacific Islander
☐ Other Race ______
☐ White
☐ Native American
☐ Caucasian
☐ Refuse To Specify
☐ Not Disclosed

Ethnicity: ○ Hispanic Or Latino ○ Not Hispanic Or Latino ○ Unknown

Preferred Language: ○ English ○ Spanish ○ French ○ Italian ○ Russian ○ Portuguese

How were you referred to our office?

☐ Phone Book ☐ School ☐ Advertisement ☐ Patient (Please Name) ______
☐ Insurance Listing ☐ Drive by ☐ Doctor (Please Name) .

Patient has received HIPAA Privacy Policy? ○ Yes ○ No **Date** ______

Notes ______

Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. All professional services and materials are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees up to 50% of charges. There will be a $10.00 service charge on all returned checks. Any account credit less than $5.00 will remain on the account for future use unless a refund is requested in writing. All credits over $5.00 will automatically be refunded to the account responsible.

Payment from my insurance is to be paid directly to Ackerson EyeCare. I understand that will be billed as my primary insurance. Ackerson EyeCare will attempt to bill the secondary insurance listed above, but I understand that any outstanding balanace is ultimately my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed. I have read the consent to use or disclose health information for the treatment, payment and health care operation and consent to the use and disclosure of my health information for the purposes of treatment, payment, and health care operations.

Signature ______ Date ______

Name

Ackerson EyeCare Inc

PRIMARY INSURANCE INFORMATION

Name and Address of Primary Insurance Company City State Zip

M ☐ F ☐

Insured's First Name MI Insured's Last Name

Insured's Identification Number Group Number Insured's Date of Birth

Patient Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status ☐ Single ☐ Married ☐ Other

☐ Full Time Student ☐ Part Time Student ☐ Employed

☐ **Insurance Card not present at Check In**

SECONDARY INSURANCE INFORMATION

Name and Address of Secondary Insurance Company City State Zip

M ☐ F ☐

Insured's First Name MI Insured's Last Name

Insured's Identification Number Group Number Insured's Date of Birth

Patient Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

☐ **Insurance Card not present at Check In**

Name

Ackerson EyeCare Inc
PATIENT HISTORY AND INFORMATION

Health history

What is the main reason for today's exam ? ____________ When was your last exam ? ____________

Past Illnesses or Injuries: ____________ ____________

Past Surgeries: ____________ ____________

Current Medications: ____________ ____________

____________ ____________

Current Eye Drops: ____________ ____________

____________ ____________

Medicines that cause reactions or sensitivities: ____________

Specific Allergies: ____________

EYE HISTORY

Condition		Condition		Condition	
Glaucoma	O Yes O No	Dryness	O Yes O No	Strabismus (Crossed Eyes)	O Yes O No
Cataract	O Yes O No	Excess Tearing/Watering	O Yes O No	Blurred Vision Distance	O Yes O No
Macular Degeneration	O Yes O No	Eye Pain or Soreness	O Yes O No	Blurred Vision Near	O Yes O No
Retinal Detachment	O Yes O No	Foreign Body Sensation	O Yes O No	Distorted Vision (halos)	O Yes O No
Color Blindness	O Yes O No	Infection of Eye or Lid	O Yes O No	Double Vision	O Yes O No
Headaches	O Yes O No	Itching	O Yes O No	Floaters or Spots	O Yes O No
Glare/Light Sensitivity	O Yes O No	Mucous Discharge	O Yes O No	Fluctuating Vision	O Yes O No
Tired Eyes	O Yes O No	Drooping Eyelid	O Yes O No	Loss of Vision	O Yes O No
Amblyopia (Lazy Eye)	O Yes O No	Redness	O Yes O No	Loss of Side Vision	O Yes O No
Burning	O Yes O No	Sandy or Gritty Feeling	O Yes O No		

GENERAL HEALTH CONDITION

Condition		Condition		Condition	
Fever	O Yes O No	Respiratory (Asthma)	O Yes O No	Anxiety or Depression	O Yes O No
Weight Loss	O Yes O No	Gastrointestinal	O Yes O No	Endocrine (Thyroid, Diabetes)	O Yes O No
Other Symptoms	O Yes O No	Kidney	O Yes O No	Blood/Lymph	O Yes O No
Ears,Nose,Throat	O Yes O No	Muscles,Bones,Joints	O Yes O No	Allergic	O Yes O No
Cardiovascular (high blood pressure etc.)	O Yes O No	Skin	O Yes O No	Are you?	☐ Pregnant ☐ Nursing
		Neurological (Multiple Sclerosis)	O Yes O No		

FAMILY HISTORY

Condition		Condition		Condition	
Amblyopia (Lazy Eye)	O Yes O No	Retinal Detachment	O Yes O No	High Blood Pressure	O Yes O No
Blindness	O Yes O No	Strabismus (Eye Turn)	O Yes O No	Kidney Disease	O Yes O No
Cataract(s)	O Yes O No	Arthritis	O Yes O No	Lupus	O Yes O No
Color Blindness	O Yes O No	Cancer	O Yes O No	Stroke	O Yes O No
Glaucoma	O Yes O No	Diabetes	O Yes O No	Thyroid Disease	O Yes O No
Macular Degeneration	O Yes O No	Heart Disease	O Yes O No	Others	O Yes O No

Name

Ackerson EyeCare Inc

MEDICAL HISTORY QUESTIONAIRE

SOCIAL HISTORY

Current Occupation : ______________ Years ________ Employer ______________

SPECTACLE LENS HISTORY

Do you use a computer? O Yes O No How many hours/day? ________ Distance from Computer? ______

Do you drive? O Yes O No Mileage to work each way? _____ Do you have glare problems? O Yes O No

Do you have visual difficulty when driving? O Yes O No

Do you have problems with night vision? O Yes O No

Do you currently wear glasses ? O Yes O No Since ____________

Type of glasses ☐ FullTime ☐ PartTime ☐ Distance ☐ Close

Glasses Owned

☐ SingleVision ☐ Bifocals ☐ Trifocals ☐ Backup ☐ Safety ☐ Sports ☐ Progressive

Have you had trouble in the past with glasses? O Yes O No ______________

Do you wear sunglasses? O Yes O No Are your sun glasses your current prescription ? O Yes O No

SPECIAL EYEWEAR NEEDS

☐ Computer (special prescriptions, special anti-glare tints or coatings) ☐ Safety Glasses (gardening, woodworking, welding)
☐ Occupational (mechanics, plumbers, pilots) ☐ Sports/Hobbies (racquet sports, motorcycle)

CONTACT LENS HISTORY

Have you ever tried to wear contact lenses? O Yes O No Reason for stopping? ____________

Do you currently wear contact lenses? O Yes O No Since ______________

If not a contact lens wearer, are you interested in trying contact lenses at this time ? O Yes O No

Type and brand of contact lenses ______________ Today's wearing time ? ______

How many hours/day ? ________ How many days/week ? ________

Please rate the following on a scale of 1-10, with 1 being POOR to 10 being EXCELLENT

	Right	Left		Right	Left		Right	Left
Lens Comfort	____	____	Distance Vision	____	____	Near Vision	____	____

What Solutions do you use? Cleaner ________ Disinfectant ________ Enzyme ________

SOCIAL HISTORY

Do you use nutritional supplements (vitamins etc.)? O Yes O No

Do you engage in regular exercise? O Yes O No

Do you drink alcohol ? If yes, how much/often : O No O Occasional O 1 per day O 2-3/day O 4+/day

Do you smoke ? If yes, how much/often : O No O Occasional O 1/2 pack/day O 1 pack/day O 1+ pack

Smoking Status ______________

Method of Tobacco Intake : O Smoking O Chewing

Do you use Illegal Drugs : O Yes O No

Hobbies/ Interests : ______________