# Look Sharp Eye Care Specialists, Ltd.

## Patient Form

Today's Date: ____/_____/_____

**Patient Information**

Name _____
Address_____ APT #_____
City_____State____Zip_____
**Phone (Cell)** _____
Phone (Home)_____
Email_____
Sex ▢Male ▢Female Age _____ Birth Date _____
Occupation _____
▢Single ▢Married ▢Divorced ▢ Separated ▢Widowed
Date of last eye exam? _____ Where? _____
Were you referred by a doctor? ▢Yes ▢No
Doctor's Name _____
Do you use tobacco? ▢Yes ▢No
Do you use alcohol? ▢Yes ▢No
Are you pregnant or nursing? ▢Yes ▢No
Allergic to Medicines?_____

**Reason For Today's Visit**

- ▢ Annual Check-Up, Not Having Any Problems
- ▢ Need Stronger Prescription
- ▢ Need More Contact Lenses
- ▢ Would Like to Try Contact Lenses
- ▢ Trouble Using Eyes Comfortably
- ▢ Other _____

Do you currently wear glasses? ▢Yes ▢No
▢All the time ▢Occasionally ▢For distance tasks ▢For near
Do you wear contact lenses? ▢Yes ▢No
Brand _____ Replacement Schedule_____

*Notice Of Privacy Practices*

I acknowledge that I have been offered a copy of Look Sharp eye Care Specialists' Notice of Privacy Practices and allow download of prescription medications.

**Signature**_____**Date**_____

*Assignment of Insurance Benefits/Payment Guarantee*

I hereby authorize payment to be made directly to Look Sharp Eye Care Specialists, Ltd. For vision plan or insurance benefits payable to me for services or materials rendered that I have received from Look Sharp eye Care Specialists, Ltd. I understand that I am financially responsible to Look Sharp Eye Care Specialists, Ltd. for any non-covered services or materials, as defined by my insurer, which is not paid by my primary or secondary insurer. I also understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, a collection fee will be added to the amount due and that I am financially responsible for the added costs also.

**Signature**_____

**Date**_____

How will you be paying for today's visit? ▢Cash ▢Check
▢Credit/Debit ▢Care Credit ▢Insurance

**Eye/Vision Concerns** Place a "✓"in any ▢ to indicate if you are experiencing any of the following:

- ▢ Blurred Vision - Distance
- ▢ Blurred Vision - Near
- ▢ Burning Eyes/DRY Eyes
- ▢ Crossed or Wandering Eye
- ▢ Crusty Eyelids or Eye Discharge
- ▢ Double Vision
- ▢ Eye Infection or Eye Injury
- ▢ Eye Strain, Fatigue, or Tiredness
- ▢ Fluctuating Vision
- ▢ Headaches
- ▢ Itching Eyes
- ▢ Light Sensitivity
- ▢ Poor Night Vision
- ▢ Red Eyes
- ▢ Seeing Flashes/Floaters/Halos/Spots
- ▢ Styes
- ▢ Temporary Loss of Vision

**Health History**

Date of your last physical_____
Primary Care Physician's Name_____

Place a "✓" in any ▢ to indicate if you or any blood relative has had any of the following problems (including parents, grandparents, uncle, aunts or siblings)

| | Yourself | Family |
|---|---|---|
| Lazy Eye | ▢ | ▢ |
| Allergies | ▢ | ▢ |
| Anxiety | ▢ | ▢ |
| Arthritis | ▢ | ▢ |
| Asthma | ▢ | ▢ |
| Blindness | ▢ | ▢ |
| Cancer | ▢ | ▢ |
| Cataracts | ▢ | ▢ |
| Depression | ▢ | ▢ |
| Diabetes | ▢ | ▢ |
| Epilepsy | ▢ | ▢ |
| Glaucoma | ▢ | ▢ |
| Head Injury | ▢ | ▢ |
| Heart Conditions | ▢ | ▢ |
| High Blood Pressure | ▢ | ▢ |
| High Cholesterol | ▢ | ▢ |
| Lupus | ▢ | ▢ |
| Macular Degeneration | ▢ | ▢ |
| Migraine Headaches | ▢ | ▢ |
| Multiple Sclerosis | ▢ | ▢ |
| Stroke | ▢ | ▢ |

| | | |
|---|---|---|
| Thyroid Dysfunction | ☐ | ☐ |
| AIDS/HIV | ☐ | ☐ |