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	▢	▢