

Welcome to . 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

\_\_\_\_\_  
Last Name First Name MI Preferred Name

\_\_\_\_\_  
Street Address City State Zip

\_\_\_\_\_  
Name Of Emergency Contact & Phone # Date of Birth Home Phone Work Phone

\_\_\_\_\_  
Social Security Number Guardian Acct Responsibility Cellular Phone

\_\_\_\_\_  
Email Address  Check box if you do NOT wish to receive **EMAIL** on special events or specials

How were you referred to our office? Who were you referred by?  
 Phone Book  Doctor  Advertisement  Patient  
 Insurance Listing  Drive by  Other  Returning Patient

**PRIMARY VISION 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** **Patient Status**  
 Self  Spouse  Child  Other  Single  Married  Other  
 Full Time Student  Part Time Student  Employed

**SECONDARY VISION 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  Self  Spouse  Child  Other  
**Patient Relationship to Insured**

**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. We would rather control billing costs than be forced to raise our fees. All professional services and material 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. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to . I understand that will be billed as my primary insurance. I understand that billing any secondary insurance is 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.

**Notice of Privacy Policies:**

I have read and/or received Dr. Satnick's Privacy Notice (HIPAA).

\_\_\_\_\_  
Signature Date

Name

# PATIENT HISTORY AND INFORMATION

## PRIMARY CARE PHYSICIAN

Primary Care Physician and Clinic Name \_\_\_\_\_

Address of Primary Care Physician \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

## HEALTH HISTORY

What is the main reason for today's exam ? \_\_\_\_\_

When was your last HEALTH exam ? \_\_\_\_\_ When was your last VISION exam ? \_\_\_\_\_

Past Illnesses or Injuries: \_\_\_\_\_

Past Surgeries: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Current Eye Drops: \_\_\_\_\_

Medicines that cause reactions or sensitivities: \_\_\_\_\_

Specific Allergies: \_\_\_\_\_

## EYE HISTORY

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

## GENERAL HEALTH CONDITION

Fever	<input type="radio"/> Yes <input type="radio"/> No	Respiratory (Asthma)	<input type="radio"/> Yes <input type="radio"/> No	Anxiety or Depression	<input type="radio"/> Yes <input type="radio"/> No
Weight Loss	<input type="radio"/> Yes <input type="radio"/> No	Gastrointestinal	<input type="radio"/> Yes <input type="radio"/> No	Thyroid, Diabetes	<input type="radio"/> Yes <input type="radio"/> No
Other Symptoms	<input type="radio"/> Yes <input type="radio"/> No	Kidney	<input type="radio"/> Yes <input type="radio"/> No	Blood/Lymph	<input type="radio"/> Yes <input type="radio"/> No
Ears,Nose,Throat	<input type="radio"/> Yes <input type="radio"/> No	Muscles,Bones,Joins	<input type="radio"/> Yes <input type="radio"/> No	Allergic	<input type="radio"/> Yes <input type="radio"/> No
Cardiovascular (high blood pressure etc.)	<input type="radio"/> Yes <input type="radio"/> No	Skin	<input type="radio"/> Yes <input type="radio"/> No	Are you?	<input type="checkbox"/> Pregnant
Neurological (Multiple Sclerosis)	<input type="radio"/> Yes <input type="radio"/> No				<input type="checkbox"/> Nursing

## FAMILY HISTORY

Amblyopia (Lazy Eye)	<input type="radio"/> Yes <input type="radio"/> No	Retinal Detachment	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No
Blindness	<input type="radio"/> Yes <input type="radio"/> No	Strabismus (Eye Turn)	<input type="radio"/> Yes <input type="radio"/> No	Kidney Disease	<input type="radio"/> Yes <input type="radio"/> No
Cataract(s)	<input type="radio"/> Yes <input type="radio"/> No	Arthritis	<input type="radio"/> Yes <input type="radio"/> No	Lupus	<input type="radio"/> Yes <input type="radio"/> No
Color Blindness	<input type="radio"/> Yes <input type="radio"/> No	Cancer	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Macular Degeneration	<input type="radio"/> Yes <input type="radio"/> No	Heart Disease	<input type="radio"/> Yes <input type="radio"/> No	Others	<input type="radio"/> Yes <input type="radio"/> No

Name \_\_\_\_\_

# MEDICAL HISTORY QUESTIONNAIRE

## SOCIAL HISTORY

Current Occupation : \_\_\_\_\_ Years: \_\_\_\_\_

Employer: \_\_\_\_\_

## SPECTACLE LENS HISTORY

Do you use a computer?  Yes  No How many hours/day? \_\_\_\_\_ Distance from Computer? \_\_\_\_\_

Do you drive?  Yes  No Mileage to work each way? \_\_\_\_\_

Do you have glare problems?  Yes  No

Do you have visual difficulty when driving?  Yes  No

Do you have problems with night vision?  Yes  No

Do you currently wear glasses ?  Yes  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?  Yes  No \_\_\_\_\_

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

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

Have you ever tried to wear contact lenses?  Yes  No Reason for stopping? \_\_\_\_\_

Do you currently wear contact lenses?  Yes  No Since \_\_\_\_\_

Type and brand of contact lenses \_\_\_\_\_ Today's wearing time ? \_\_\_\_\_

How many hours/day ? \_\_\_\_\_ How many days/week ? \_\_\_\_\_

**Please rate your CONTACT LENSES on the following scale of 1-10, with 1 being POOR to 10 being EXCELLENT**

Lens Comfort 

	Right	Left		Right	Left		Right	Left
_____	_____	_____	Distance Vision	_____	_____	Near Vision	_____	_____

What Solutions do you use? Cleaner \_\_\_\_\_ Disinfectant \_\_\_\_\_ Enzyme \_\_\_\_\_

## SOCIAL HISTORY

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

Do you engage in regular exercise?  Yes  No

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

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

Method of Tobacco Intake :  Smoking  Chewing

Do you use Illegal Drugs :  Yes  No

Hobbies/ Interests : \_\_\_\_\_