Last Name			First Name:		
Address:			DOB:	Age:	
City:	State:		Zip Code:		
Home Phone:	Cell Phone:		Work Phone:		
Email Address:			How did you hear about our office?		

INSURANCE INFORMATION

Do you have vision insurance?	If yes, insurance carrier:
Do you have health insurance? □ Yes □ No	If yes, insurance carrier:

INTERVIEW

Eye Conditions		**Eye Concerns**	
Cataract	□ Yes □ No	Redness	□ Yes □ No
Macular degeneration	□ Yes □ No	Burning	□ Yes □ No
Glaucoma	□ Yes □ No	Itching	□ Yes □ No
Diabetic retinopathy	□ Yes □ No	Tearing	□ Yes □ No
Dry eye	□ Yes □ No	Discharge	□ Yes □ No
Infection, inflammation	□ Yes □ No	**Computer Demands**	
Floaters/flashes	□ Yes □ No	Do you use a computer?	□ Yes □ No
Iritis or uveitis	□ Yes □ No	Unusual ergonomic demands	□ Yes □ No
Retina defects/degeneration	□ Yes □ No	Paperwork and computer use	□ Yes □ No
Vision Concerns		Do you use a laptop?	□ Yes □ No
Blurred vision	□ Yes □ No	Do you use multiple monitors?	□ Yes □ No
Eyestrain	□ Yes □ No	Hours of computer use, per day _____	
Eye pain	□ Yes □ No	**Vision Correction History**	
Severe light sensitivity	□ Yes □ No	Do you wear glasses?	□ Yes □ No
Headache	□ Yes □ No	If so, how old is current pair	
Poor night vision	□ Yes □ No	Do you wear contact lens?	□ Yes □ No
Bothersome night glare	□ Yes □ No	If so, what brand of lens: _____	
Double vision	□ Yes □ No	Average daily wearing time: _____	
Total loss of vision	□ Yes □ No	Today's wearing time: _____	
		Average replacement period: _____	
		Continuous wear period:_____	
		Solutions used: _____	

Do, you, or a family member (parent, grandparent, sibling), currently have or have a history of any of the following conditions?							
Constitutional	**Self**	**Family**	**Relation**	**Gastrointestinal**	**Self**	**Family**	**Relation**
Development Disabilities	□	□		Crohn's	□	□	
Cancer	□	□		Colitis	□	□	
Fatigue Syndrome	□	□		Ulcer	□	□	
				Acid Reflux	□	□	
Ear, Nose and Throat				Celiac Disease	□	□	
Hearing loss	□	□					
Sinusitis	□	□		**Skin**			
Dry mouth	□	□		Psoriasis	□	□	
Laryngitis	□	□		Eczema	□	□	
Neurological				**Musculoskeletal**			
Multiple Sclerosis	□	□		Arthritis	□	□	
Epilepsy	□	□		Osteoarthritis	□	□	
Cerebral Palsy	□	□		Fibromyalgia	□	□	
Tumor	□	□		Muscular Dystrophy	□	□	
Stroke/CVS	□	□		Osteoporosis	□	□	
Migraine	□	□					
Autism Spectrum Disorder	□	□		**Endocrine**			
				Type 2 Diabetes	□	□	
Psychiatric				Type 1 Diabetes	□	□	
Depression	□	□		Thyroid Dysfunction	□	□	
Attention Deficit	□	□		Hormonal Dysfunction	□	□	
Anxiety	□	□					
Bipolar	□	□		**Immune System**			
				Rheumatoid Arthritis	□	□	
Cardiovascular				Lupus	□	□	
Hypertension	□	□		Sjogrens Syndrome	□	□	
Stroke/CVS	□	□					
Heart Disease	□	□					
				Known Allergies			
Respiratory				Medication Allergies	□	□	
Asthma	□	□		Medication Name:			
Chronic Bronchitis	□	□		Other Allergies:	□	□	
Emphysema	□	□		Type:			
Sleep Apnea	□	□					

Current Medications:

Social History

Alcohol Use: □ No □ Occasional □ 1 per day □ 2-3 per day □ 4 + per day

Tobacco Use: □ No □ Occasional □ ½ pack per day □ 1 pack per day □ 1 + pack per day

Method: □ Cigarette □ Cigar □ Chewing □ Pipe

Do you use recreational drugs? □ No □ Yes

Hobbies:

Keller Eye Care

PATIENT INFORMATION		
DATE:	DOB:	SSN:
LAST NAME:	FIRST NAME:	
ADDRESS:		
HOME PHONE:	WORK PHONE:	CELL PHONE:
LEAVE MESSAGE WITH:	☐ DETAILED INFORMATION ☐ CALL BACK NUMBER ONLY	
PREFERRED CONTACT:	☐ HOME ☐ WORK ☐ CELL ☐ E-MAIL ☐ TEXT	
PRIMARY CARE PROVIDER:		
PLACE OF EMPLOYMENT:		
DO YOU HAVE VISION INSURANCE? IF YES, Insurance Name:_____Group:_____ Member ID: _____, Primary Insured _____		
DO YOU HAVE MEDICAL INSURANCE? IF YES, Insurance Name: _____Group:_____ Member ID: _____, Primary Insured _____		

I hereby authorize Keller Eye Care to release any information with respect to this claim to my insurance company. I understand that any benefits payable for goods and services will be paid to Keller Eye Care to the extent I have not already paid or the entire amount of such benefits. I understand that I will be responsible for any bill incurred in the office regardless of insurance coverage. All copays/coinsurance are due at the time of service. Accounts ninety days old are subject to collection fees. There will be a service charge on all return checks.

My signature acknowledges my receipt and understanding of Keller Eye Care's "Notice of Privacy Practices."

_____ _____

Patient/Guardian Signature: Date