WELCOME TO LOOK! OPTOMETRY

PATIENT INFORMATION: (Must be updated at every visit)

□New Patient □ Previous Patient **Today's Date**_____

Last Name_____ First Name_____ □Male □Female □Other

Address_____City_____State_____ZIP_____

Birthdate_____Age_____Home/Cell Phone_____Work Phone_____

Email_____Occupation_____Employer_____

Reason For Today's Visit

□Glasses Exam /Routine Eye Examination
□Contact Lens Exam and Lenses
□Refractive Surgery (LASIK) Evaluation
□Noticing change in vision
□Retinal Photo (For monitoring patients with high blood pressure, diabetes, glaucoma, macular degeneration, etc.)
Date Of Last Eye Exam _____ □Other_____

Medical and Eye History

Primary Care Physician Name_____ Date of Last Visit_____

Do You Have:		**Does anyone in your family have:**	
High Blood Pressure	□No □Yes	High Blood Pressure	□No □Yes
Diabetes	□No □Yes	Diabetes	□No □Yes
Heart Disease	□No □Yes	Heart Disease	□No □Yes
High Cholesterol	□No □Yes	High Cholesterol	□No □Yes
Cancer	□No □Yes	Cancer	□No □Yes
Glaucoma	□No □Yes	Glaucoma	□No □Yes
Cataracts	□No □Yes	Cataracts	□No □Yes
Inherited Diseases	□No □Yes	Inherited Diseases	□No □Yes
Allergies	□No □Yes	Allergies	□No □Yes

Any Other Health Problems_____ Any Eye Problems/Surgeries_____

Are you pregnant? □Yes □No

Did you have **LASIK**? □Yes □No If yes, when?_____

List any **medications** you are taking_____

Allergies to any medication?_____

Do you use cigarettes/tobacco?_____Alcohol?_____ Other substances?_____

Contact Lens Information:

Do you wear contact lenses? □No □Yes Would you be interested? □Yes □No

If yes: □ Soft □ Conventional
□ Hard/Gas Permeable □ Disposable How often do you change lenses?_____
□ I remove them before sleeping □ I sleep in my contacts How many days maximum?_____

Medical Insurance: □HMO □PPO If PPO, what type:_____

Name of Insurance Vision Service Plan (VSP) / EyeMed / MES / Spectera / Davis / Other_____

Your Social Security Number: _____

Primary Member's Name: _____ Primary Member's Birthdate_____

Relation to Member □Self □Spouse □Dependent

Primary Member's Social Security Number: _____

Are there other family members that would benefit from an eye exam?_____

I hereby authorize payment of my insurance benefits to Look! Optometry. I understand I am financially responsible for any charges, whether or not paid by said insurance. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Look! Optometry. I authorize Look! Optometry to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original. PAYMENT OF INSURANCE DEDUCTIBLES DUE ON DATE OF SERVICE.

- I acknowledge that I have read the Look! Optometry Notice of Privacy Practices Form. INT_____

Signature_____Date_____