

# Look Optical

Name			Date	
Address			Social Security	
City	State	Zip	Date of Birth	Age
Home Phone	Work Phone		Occupation	
Approximate Date Of Last Eye Examination			E-mail Address	

**How Did You Hear About Our Office :**

Drive by     Phone Book     Insurance     Referred By Friend Or Relative \_\_\_\_\_  
 P **Previous Patient**     Advertisement

**WHAT BRINGS YOU TO OUR OFFICE TODAY ?**  
( PLEASE CHECK ALL THAT APPLY )

<input type="checkbox"/> Routine, no complaints	<input type="checkbox"/> Eye strain
<input type="checkbox"/> Want contact lenses	<input type="checkbox"/> Frequent headaches
<input type="checkbox"/> Want glasses	<input type="checkbox"/> Double vision
<u>Blur at far</u>	<input type="checkbox"/> Burning, stinging eyes
<input type="checkbox"/> With Glasses <input type="checkbox"/> W/O Glasses	<input type="checkbox"/> Tearing
<u>Blur at near</u>	<input type="checkbox"/> Red eye / eye infection
<input type="checkbox"/> With Glasses <input type="checkbox"/> W/O Glasses	<input type="checkbox"/> Floaters / Flashes

**DO YOU CURRENTLY:**  
( PLEASE CHECK ALL THAT APPLY )

<input type="checkbox"/> Wear glasses	<input type="checkbox"/> Wear contacts
SOFT CONTACTS	
<input type="checkbox"/> Disposable	<input type="checkbox"/> Toric ( for astigmatism )
<input type="checkbox"/> Frequent replacement	<input type="checkbox"/> Bifocal
( Or <input type="checkbox"/> Gas permeable hard lenses )	
<input type="checkbox"/> Sleep in your contacts	
<input type="checkbox"/> Work at computer	Hours per day _____

**EYE HEALTH: DO YOU NOW OR HAVE YOU EVER HAD?**  
( PLEASE CHECK ALL THAT APPLY )

<input type="checkbox"/> Eye injury	<input type="checkbox"/> Lazy eye ( Amblyopia )
<input type="checkbox"/> Eye surgery	<input type="checkbox"/> Strabismus ( Eye turn )
<input type="checkbox"/> Cataract	<input type="checkbox"/> Vision therapy
<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Family history of glaucoma

**PERSO NAL HEALTH HISTORY: DO YOU HAVE ?**  
( PLEASE CHECK ALL THAT APPLY )

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Allergies / Hay Fever
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Other _____
<input type="checkbox"/> Pregnant	_____

Please list all medications?

Are you allergic to any medications?

<b>DILATION</b>	<p>Drops are used to enlarge the pupil, allowing the doctor to see a more complete view of the retina. Without drops, only a limited portion can be viewed. The dilation is necessary to completely rule out the presence of cataracts, glaucoma, macular degeneration and other retinal disease.</p> <p>PUPIL DILATION IS ESSENTIAL IF YOU ARE DIABETIC OR _____ OVER 60 YEARS OF AGE .</p> <p>The drops will cause light sensitivity and mildly blurred vision, especially up close, for approximately four to five hours. Most patients are able to drive safely afterwards.</p> <p>Initial _____ Yes – I want dilation included // Initial _____ No – I understand the above and do not want dilation.</p>
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**INSURANCE DISCLAIMER**

Please be advised that if we are not made aware of your vision insurance at the time of service we will be unable to submit the claim for you. However, we will be more than happy to provide you with an itemized receipt so that you can submit the claim yourself and your insurance company may reimburse you directly.

I have answered the above questions to the best of my knowledge. I understand that I am responsible for payment at the time of service.

SIGNED \_\_\_\_\_

**METHOD OF PAYMENT**

CASH  
 CHECK  
 CREDIT CARD

**VISION INSURANCE**

PLEASE LIST

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