

Date: \_\_\_\_\_

## **Welcome to Limerick Eye Associates, PC**

Mr.  Mrs.  Dr.  Miss  Ms.  Rev.

Patient's name \_\_\_\_\_

Preferred Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Preferred Contact Number \_\_\_\_\_

Email address \_\_\_\_\_ May we contact you by email? **Y** **N**

Can we leave personal/medical information on a voicemail/ answering machine or with a family member?  **Y**  **N**

Are there any family members that you allow us to discuss your personal information with? If so, please list name and relationship

\_\_\_\_\_

How did you hear about our office? (See below)

Insurance listing on Internet  Word of Mouth  Internet Search  Physician  ByTheZip.com

Other \_\_\_\_\_

And if you were referred, whom may we thank? \_\_\_\_\_

Occupation \_\_\_\_\_

Name of employer \_\_\_\_\_ City \_\_\_\_\_

Special visual demands (work or hobbies) \_\_\_\_\_

Name of spouse \_\_\_\_\_

Please list any other family members that come here \_\_\_\_\_

**(Please See Other Side)**

*You're almost done!!*

Do you have any of the following:  Y (**Please Circle Below**)  N

Cataracts / Glaucoma / Lazy Eye / Macular degeneration / Diabetes / High blood pressure / Allergies

Any immediate family history (parents, grandparents, siblings) of the following:  Y (**Please Circle Below**)  N

Glaucoma / Macular degeneration / Diabetes

Have you ever had any injury or surgery to your eyes?  Y  N Describe \_\_\_\_\_

Do you smoke?  Y  N

Are you currently pregnant or nursing?  Y  N

List any other medical/eye health problems \_\_\_\_\_

Current List of Medications including drops (**Both prescribed and Over-the Counter**)

\_\_\_\_\_  
\_\_\_\_\_

Family physician/location \_\_\_\_\_ Date Last Seen \_\_\_\_\_

Previous eye doctor /location \_\_\_\_\_ Date Last Seen \_\_\_\_\_

Allergies to any medications, drops or contact lens solutions?  Y  N (List) \_\_\_\_\_

Do you presently wear glasses?  Y  N How old are the glasses? \_\_\_\_\_

Do you wear glasses for driving?  Y  N

Are you planning on purchasing new glasses today?  Y  N  Only if there is a change

Do you presently wear contact lenses?  Y  N If no, have you ever worn contacts?  Y  N

As a contact lens wearer, do you have backup eyeglasses?  Y  N

Are you interested in wearing contact lenses?  Y  N

Are you interested in LASIK?  Y  N

Do you have vision care insurance?  Y  N Name \_\_\_\_\_

Do you have medical insurance?  Y  N Name \_\_\_\_\_

**Please note:**

Insurance may cover none or only part of your fees. If we do not accept direct payment from your insurance plan, you will pay our office at the time of service and submit your receipt for reimbursement to your insurance company. If your insurance does not pay as expected, you are ultimately responsible for all charges. We cannot be responsible if you are not eligible for benefits. We will be happy to assist you with your claims, please give any forms to the receptionist.

I acknowledge that I have been offered the *Notice of Privacy Practice* from Limerick Eye Associates, PC.

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

Are you signing as a parent or legal guardian?  Y  N Please print name: \_\_\_\_\_