



649 N. Lewis Rd., Suite 120  
Limerick, PA 19468  
Phone: 610-495-6851  
www.limerickeyeassociates.com

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

***Welcome to Our Office!!***

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 Way To Contact (Please Mark All That You Allow Us)  Cell  Text  Work  Home  Email

Email address \_\_\_\_\_

Circle the Social Media You Use: Facebook Twitter LinkedIn Other \_\_\_\_\_

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  Word of Mouth  Internet  Physician Referral  Family Member(s) Come Here  Walking By

CareCredit If you did an internet search, what words did you use? \_\_\_\_\_

If you were referred, whom may we thank? \_\_\_\_\_

Occupation \_\_\_\_\_

Name of employer \_\_\_\_\_ City/State \_\_\_\_\_

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

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

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

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

Glaucoma / Macular degeneration / Lazy Eye/ Diabetes

Any injuries or surgeries 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 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 and read 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: \_\_\_\_\_

Name: \_\_\_\_\_

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

## Lifestyle Questionnaire

In order for us to provide the best eyewear options to fit your lifestyle, we would like to know how you use your eyes at work and home.

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How many pairs of prescription glasses do you currently use? \_\_\_\_\_

If you wear single vision glasses are they (Circle one)

For Distance Only      For Reading Only

Do you wear Bifocals?  Y  N Trifocals?  Y  N      Progressive (No line)?  Y  N

When watching TV, do your progressive or bifocal lenses get in the way?  Y  N  N/A

Are you interested in lenses that provide high definition (HD) optics?  Y  N

Do you wish your lenses were lighter/thinner?  Y  N

Are you interested in or have you worn lenses that darken in sunlight called Transitions?  Y  N

Are you bothered by glare?  Y  N      Is safety protection a concern during sports?  Y  N  N/A

On your way home or to work, do you drive toward the sun?  Y  N

Do you wear sunglasses?  Y  N      Are they prescription?  Y  N      Are they polarized?  Y  N

### **Tell Us How You Are Using Your Eyes**

At work, do you read small print?  Y  N      Do you perform fine or up-close work?  Y  N

Are you outdoors all or part of the time?  Y  N

How much time do you spend on a computer daily?(circle one)      None      1-2hrs      3-6hrs      More

Does your occupation require eye protection?  Y  N

Do you do chores around the house that pose a danger to your eyes?  Y  N

Do you participate in any sports or recreational activities?  Y  N

If yes, what kind? (Please circle all that apply) Aerobics/Fitness Walking      Basketball      Fishing      Football

Golf      Martial Arts      Racquet Sports      Shooting Sports      Soccer      Volleyball      Baseball/Softball      Cycling

Handball      Motorcycle      Rollerblading/Skateboarding      Skiing/Snow Sports      Swimming      Water Sports