

# WELCOME

Dr. Kennedy & Staff welcome you to Perspective Eyecare!  
Please fill out this form completely. The better we communicate, the better we can care for you.

## PATIENT INFORMATION (INITIAL IF THERE ARE NO CHANGES \_\_\_\_\_)

Today's Date \_\_\_\_\_  
Name \_\_\_\_\_  
Last First M Mr Mrs Ms Dr  
I prefer to be called: \_\_\_\_\_  Male  Female  
Birth date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ SS#: \_\_\_\_\_  
Parent/Guardian (if minor) \_\_\_\_\_  
Address: \_\_\_\_\_  
City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_  
 Single  Married  Divorced  Widowed  Separated  Domestic Partner  
\*Email Address: \_\_\_\_\_  
Hm#:(\_\_\_\_\_) \_\_\_\_\_ Cell#:(\_\_\_\_\_) \_\_\_\_\_  
Wk#:(\_\_\_\_\_) \_\_\_\_\_ DL# \_\_\_\_\_  
Employment:  Full-time  Part-time  Retired  Student  Not Employed  
Employer: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Where & when are best times to reach you? \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
Previous Optometrist/Ophthalmologist \_\_\_\_\_  
Last Examination Date: \_\_\_\_\_  
\*Email used for notification purposes only. It will never be shared or sold.

## SPOUSE INFORMATION (INITIAL IF THERE ARE NO CHANGES \_\_\_\_\_)

His / Her Name: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Wk#:(\_\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_  
SS#: \_\_\_\_\_ Birth Date \_\_\_/\_\_\_/\_\_\_

## INSURANCE COVERAGE (INITIAL IF THERE ARE NO CHANGES \_\_\_\_\_)

Insurance Co. Name: \_\_\_\_\_  
Group# \_\_\_\_\_ Plan/Policy#: \_\_\_\_\_  
Insured's ID#: \_\_\_\_\_  
Insured's Name: \_\_\_\_\_  
Insured's Birth Date: \_\_\_/\_\_\_/\_\_\_  
Insured's SS#: \_\_\_\_\_  
Insured's Employer: \_\_\_\_\_  
Relationship to Insured: \_\_\_\_\_

## GENERAL INFORMATION

Reason for today's visit: \_\_\_\_\_  
Type of exam you are here for today:  
 Glasses  Contact Lenses  Both  
Are you presently wearing or have you ever worn:  
 Glasses  Contacts  Both  Neither  
Are you interested in learning more about LASIK / refractive surgery?  Yes  No  
Do you have problems with night vision?  Yes  No  
Do you use a computer?  No  Yes (Hrs per day \_\_\_)  
What types of hobbies/sports are you active in?  
\_\_\_\_\_  
Please mark the items that you would like more information about:  Transitions Lenses  Anti-Glare Coatings  Sunglasses  Super Thin Materials  Progressive/No Lines  Polarization  Other \_\_\_\_\_

## VISUAL FIELDS EXAMINATION

A highly sophisticated computerized instrument allows us to provide a more thorough medical analysis of your eyes by testing visual fields, or peripheral vision. This evaluation of the visual field is important in detecting ocular disorders that reduce peripheral vision *before* central vision is affected, such as in glaucoma, retinal disease, and neurological disorders.

We **strongly** recommend that all of our patients over the age of twenty (20) and/or who have the following receive this test.

- Personal or family history of glaucoma
- Headaches
- History of Diabetes
- High Myopia (Nearsightedness)
- High Spectacle Prescription
- Visual Floaters, flashes, or spots
- Circulatory Problems/High Blood Pressure

This procedure requires a small amount of additional examination time. The cost for a basic screening procedure starts at \$49.00 *but may be covered by your insurance company.*

- I would like a Basic Visual Field Screening
- I understand the importance of the Visual Field Evaluation, but at this time, I prefer to have the routine eye examination only. \_\_\_\_\_ **Initial Here**

**CONTINUED ON BACK**

**MEDICAL INFORMATION** (INITIAL HERE IF THERE ARE NO CHANGES \_\_\_\_\_. PLEASE DOUBLE CHECK MEDICATIONS ON FILE)

List any medications you currently take (including prescription, over-the-counter and herbal and / or supplements). If you have a list, we will be happy to copy it for you.

Do you have any allergies to medications or seasonal allergies? Please list: \_\_\_\_\_

Please list any eye surgeries you have had (cataract, LASIK, eye muscle, etc.) & when \_\_\_\_\_

Do you **currently** have any of the following conditions / problems?

YES	NO	CONDITION / PROBLEM
		Loss of Vision
		Loss of Side (Peripheral) Vision
		Flashes / Floaters in Vision
		Blurred Vision
		Distorted Vision (Halos)
		Glare / Light Sensitivity
		Double Vision
		Mucous Discharge
		Sandy or Gritty Feeling
		Excessive Dryness
		Foreign Body Sensation
		Excessive Itching
		Excessive Burning
		Excessive Tearing / Watering

YES	NO	CONDITION / PROBLEM
		Redness
		Eye Pain or Soreness
		Tired Eyes
		Crossed Eyes / Lazy Eye
		Headaches
		Migraines
		Skin problems (skin cancer, etc.)
		Seizures
		Allergic/Immunologic (hay fever, lupus, etc.)
		Ear, nose, throat (sinus, chronic cough, etc.)
		Muscle, Bone or Joint Problems (arthritis, etc.)
		Endocrine Problems (thyroid disorder, etc.)
		Multiple Sclerosis
		Blood/Lymphatic (high cholesterol, anemia, etc.)

**FAMILY HISTORY** (INITIAL IF THERE ARE NO CHANGES TO YOUR MEDICAL HISTORY \_\_\_\_)

MEDICAL ISSUE	SELF	MOTHER	FATHER	SIBLING	MATERNAL GRANDPARENT	PATERNAL GRANDPARENT
Cataracts						
Glaucoma						
Macular Degeneration						
Retinal Detachment						
Blindness						
Diabetes						
High Blood Pressure						
Stroke						
Heart Disease						

**PAYMENT IS DUE AT TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE**

I believe that the information that I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical, personal or insurance status. I understand that by signing this form I am allowing my information to be released upon my insurance company's request for purposes including, but not limited to, provider review, claims payment and quality assessment. I authorize payment of medical/vision benefits directly to Dr. Kennedy/Perspective Eyecare for services rendered. Non-covered expenses are due at the time of service. Perspective Eyecare will seek verification of vision eligibility prior to services rendered but I understand it is not a guarantee of payment by my insurance company. *I fully understand I am responsible for any amount not paid by my insurance and that this amount is due within 30 days of notification.* **I understand this office is HIPAA compliant and that I have been given the option of receiving a copy of its Notice of Privacy Practices.**

**Contact Lens Wearers:** I understand that the fees associated with the fittings and examination for contact lenses may not be covered by my insurance and I am prepared to pay these additional fees. I understand that many variable exist in the fitting and wearing of contact lenses and that not every contact lens fitting will be successful. If for any reason the contact lenses do not work for me, I understand the professional fees are non-refundable.

Signature (Patient or Parent)

Date