Guardian: _____ **Date:** _____

Name: _____

Address: _____

City, St: _____ **Zip:** _____

Phone(H): _____ W: _____ C: _____

Date of Birth: _____ **Sex:** _____

E-Mail: _____

Occupation: _____

Notify me by: ☐ Text ☐ Phone ☐ Email ☐ Mail

Who may we thank for referring you to our office?

☐ Friend ☐ Insurance ☐ Phone Book ☐ Other…

Emergency Contact Name and Phone:

_____

Approx. Date of Last Eye Exam: _____

What is the major purpose of this visit:

- ☐ Blur at Far
- ☐ Blur at Near
- ☐ Blur at Far & Near
- ☐ Itching
- ☐ Burning
- ☐ Redness
- ☐ Eye pain
- ☐ Eye strain
- ☐ Flashes/Floaters
- ☐ Loss of vision
- ☐ Double vision
- ☐ Sandy/Gritty
- ☐ Spots or shadows
- ☐ Diabetes eye check
- ☐ Medical eye check
- ☐ Other:

Which Eye? ☐ Right eye ☐ Left eye ☐ Both eyes

How long has it bothered you?

- ☐ Started today
- ☐ 1-2 days
- ☐ 3-7 days
- ☐ 1-2 weeks
- ☐ 2-4 weeks
- ☐ 1-3 months
- ☐ 3-6 months
- ☐ Over 6 months

Severity? ☐ Mild ☐ Moderate ☐ Severe

Getting Worse?

☐ Getting better ☐ Getting worse ☐ About the same

Current Prescription:

Glasses: Right _____

Left _____

Contacts: Right _____

Left _____

Medical Doctor(s):

Michigan Eye and Contact Lens

42081 West 14 Mile Rd
Novi, MI 48377
248.859.4221
Fax- 248.859.4724
E-mail: info@micontactlens.com
http://www.micontactlens.com/

Race
- ○ American Indian or Alaska Native
- ○ Asian
- ○ Black or African-American
- ○ Native Hawaiian or Other Pacific Islander
- ○ Other Race
- ○ Unknown/undetermined
- ○ White

Ethnicity
- ○ Not Hispanic or Latino 2186-5
- ○ Hispanic or Latino 2135-2

Language ☐ English ☐ French ☐ Mandarin ☐ Other… ☐ Spanish ☐ Japanese ☐ Unknown

Smoking
- ○ Ex-smoker
- ○ Heavy tobacco smoker
- ○ Light tobacco smoker
- ○ Never smoked tobacco
- ○ Tobacco Smoking Consumption unknown

Please note that insurance does NOT cover the Contact Lens Fitting Evaluation

Vision or Primary Insurance

Ins. Name: _____

Ins Number: _____

Relationship: _____

Insured: _____

Insured DOB: _____ **Ins. Sex:** ○ M ○ F

Co-pay: _____ **Materials:** ○ Y ○ N

Medical or Secondary Insurance

Ins. Name: _____

Ins Number: _____

Relationship: _____

Insured: _____

Insured DOB: _____ **Ins. Sex:** ○ M ○ F

Co-pay: _____ **Materials:** ○ Y ○ N

Participate in a flex spending account? ☐ Y ☐ N

Past Medical History

- ☐ Allergy
- ☐ Amblyopia
- ☐ Asthma
- ☐ Cataract
- ☐ Crossed Eyes
- ☐ Diabetes 1
- ☐ Diabetes 2
- ☐ Droopy Lid
- ☐ Ear
- ☐ Eye Infection
- ☐ Eye Injury
- ☐ Glaucoma
- ☐ Heart disease
- ☐ High B.P.
- ☐ Keratoconus
- ☐ Kidney
- ☐ Lasik
- ☐ Macular Degen.
- ☐ Melanoma
- ☐ Migraine
- ☐ MS
- ☐ Respiratory
- ☐ Sinusitis
- ☐ Stye
- ☐ Thyroid
- ☐ Other…

Eye wear History

- ☐ Glasses
- ☐ Bifocals
- ☐ Trifocals
- ☐ No- line
- ☐ Soft Contacts
- ☐ Toric Soft
- ☐ Gas Perm
- ☐ Hard
- ☐ Monovision
- ☐ Disposable
- ☐ Overnight wear
- ☐ CRT

Mark box if yes.

- ☐ Have you tried contact lenses?
- ☐ Not satisfied with the vision comfort of contacts?
- ☐ Would you prefer colored contacts?
- ☐ Do the bifocal's lines and head tilting bother you?

Drug Allergies

- ☐ None
- ☐ Penicillin
- ☐ Sulfa
- ☐ Eye drops
- ☐ Other…

Social History

- ☐ Computer
- ☐ Reading
- ☐ Student
- ☐ Music
- ☐ Skiing
- ☐ Golf
- ☐ Fishing
- ☐ Tennis
- ☐ Swim
- ☐ Bike
- ☐ Drug Abuse
- ☐ Alcohol Abuse
- ☐ No alcohol or drug abuse
- ☐ Other…

Current Medicines	Amount

Family History

- ☐ Blindness
- ☐ Cancer
- ☐ Crossed Eyes
- ☐ Color Blind
- ☐ Diabetes 1
- ☐ Diabetes II
- ☐ Kidney
- ☐ Macular Degen.
- ☐ Retina Detach
- ☐ Heart Disease
- ☐ High B.P.
- ☐ Thyroid
- ☐ Glaucoma
- ☐ None
- ☐ Other:

Lifestyle Questions

Do you...(Check box if your answer is yes)

- ☐ Work at a computer or tablet often?
- ☐ Think you might benefit from thinner lenses?
- ☐ Would like to "test drive" the latest contact lenses?
- ☐ Spend time outdoors?
- ☐ Prefer not to wear your glasses at times?
- ☐ Want info. on Laser Vision Correction surgery?
- ☐ Have more than 1 pair of current Rx eyewear?

Our office requires payment at the time of service unless we "accept assignment" on your insurance. **You are responsible if your insurance doesn't pay.** Should collection become necessary, I agree to pay all attorney's fees, court costs, filing fees, and all collection costs up to 33.33% of the amount owing which may be assessed by a collection agency. I/We further agree to pay $2.00 every two weeks on balances over 60 days old. **Contact lens fit and follow up care is billed separately from your eye exam.** Your information is protected by our privacy policy and is available online for your "Health Vault" by asking for instructions. *I have received a copy of Michigan Eye and Contact Lens "Notice of Privacy Practices".*

Remind me of my appointment by: ☐ Text

Signature_____ Date_____

Relationship to Patient: _____

Exam:
____ Dilating ____Photos ____ Auto Refraction/Keratometry ____ Topography ____ Visual Fields

Glasses:
____ Frame Style/Disp. ____ Repair ____ PAL ____ Poly ____ AR ____ Trans ____ Sunglasses ____ Readers ____ Computer

Contacts:
____ I&R ____ Polish

Schedule:
____ VA ____ LASIK ____ Visual Fields ____ Photos ____ Dilation ____ IOP ____ Punctal Plugs ____ CLE ____ VT Instructionl

MISC:
Records Release Checkout