Patient Information

Thank you for choosing us as your eye care provider. Please help us better meet your needs by updating the information below

Today's Date:

First name: Middle: Last Name:
Nick Name: Patient Sex:
Address: City: State: Zip:
Cell Phone: Home Phone: Work Phone:
Email:
SSN: DOB: Age:
Employer: Occupation:
Employment Status: Full-Time Part-Time Student Full-Time Student Part-Time
Marital Status:

***INFORMATION REQUIRED* to bill insurance company, and to meet government guidelines:**
Government Guidelines:

Preferred Contact Type: Email Phone Mail
Language Preferred_____

Vision-related sports, hobbies, or special visual needs_____
_____

Purpose of Todays Visit

__Distance Blur__Near Blur __Redness __Itching __Burning __Pain __Light Sensitivity
__Need New Glasses __Glaucoma Testing __Cataract Check __Interested in Contacts
__Laser Surgery Evaluation __Other_____

Please circle **"S" for self, and "F" for family (or both)** for present or past conditions below.
Circle specific choices for listed items if applicable (ex. Floaters but no Flashes)

S F Double Vision
S F Sudden Loss of Vision
S F Retinal Diseases
S F Eye Turn "Lazy Eye"
S F Diabetes
S F Intestinal Digestive Disorders
S F Kidney Liver Diorders
S F High Blood Pressure
S F Hearing Problems
S F Auto Immune Diseases
S F Asthma Bronchitis Lung Problems
S F Flashes Floaters Spots
S F Glaucoma
S F Eye Injury Head Injury
S F Dry Eye
S F Thyroid Conditions
S F Cancer Tumor
S F Fainting Dizziness
S F HIV AIDS
S F Vision Training/Therapy
S F Concentration/Memory Problems
S F Color Blindness
S F Heart Conditions
S F Blindness
S F Eye Surgery
S F Headaches
S F Skin Conditions
S F Arthritis
__**NO Known Conditions**

Women: Are you Pregnant? Yes No Nursing? Yes No

Allergies Full List:

Do you currently use: Alcohol Yes No Tobacco: Yes No Other Substances: Yes No
Please list any current medications (including birth control, vitamins, any over the counter drugs, etc.): _____
_____
_____

Primary Doctor:
Phone Number:
Date of last complete eye exam (including glaucoma testing):
Date of last physical:

For Contact Wearers Only

In Compliance with the **Contact Lens Rule and the FTC**, I authorize Eye Logic to give me access to my finalized contact lens prescription through my patient portal.

Signature_____ Date:_____

Are you wearing contact lenses today? Yes No Brand_____
Age of current pair_____ Solution Used_____
Average # of hours worn daily_____hours X_____days of week
Do you sleep in your contacts? Yes No **IF YES** how many times per week?_____
How often do you replace your lenses with a fresh pair?_____
On a scale of 1 to 10 **(10 being the BEST)** how comfortable are your lenses?_____

Insurance Information

Insurance 1 Name:
Ins ID: Ins 1 Policy Group:
Ins 1 Address: City: State: Zip:
Ins 1 Phone:
Ins 1 Primary Name:
Ins 1 Birthday: Sex:
Ins 1 SSN:

Insurance 2 Name:
Ins 2 ID: Ins 2 Policy Group:
Ins 2 Address: City: State: Zip:
Ins 2 Phone:
Ins 2 Primary Name:
Ins 2 Birthday: Sex:
Ins 2 SSN:

It is the patient's responsibility to know their individual benefit coverage.
To email insurance card: contact@eyelogicco.com

PLEASE READ AND SIGN THE FOLLOWING CONSENT REQUESTS. If you do not wish to give permission to any of the following requests please indicate that *YOU DO NOT GIVE PERMISSION*:

I have read and understand the following: Payment is due at time for services rendered. Full payment is due before products will be released. A restocking fee of 10% will be charged for products not picked up within 60 days unless otherwise arranged. I accept responsibility for payment of all charges whether covered by insurance or not. There are no refunds on professional fees.

Signature_____ Date_____
Responsible Party

I give permission for this office to exchange my medical information with other health care providers if a referral is needed.

Signature_____ Date_____
Responsible Party

I give permission for Eye Logic and/or Dr. Amy Gallegos and Associates to contact me via electronic communication routes for appointment reminders, marketing, or any other instances that may be related to my health.

Signature_____ Date_____
Responsible Party

I give permission for the person(s) listed below to pick-up my ophthalmic products.

Please list Name(s) and DOB(s):

Signature_____ Date_____
Responsible Party

WE WILL NOT SHARE YOUR E-MAIL ADDRESS WITH OTHER COMPANY OR BUSINESS