Thank you for choosing Castle Rock EyeWear to care for your eyes

Mr. Mrs. Ms. Dr. Name_____ **Age** _____ **Date**_____
Last First MI

Address_____ **City** _____ **State** _____ **Zip Code** _____

Phone Home:_____**Work:** _____**Cell:** _____ **preferences please mark all that apply** **EMAIL** ☐ **TEXT** ☐ **PHONE** ☐

E-mail _____**Occupation** _____ **Birth Date** ____/____/____

Previous Patient Y○ N○ **How did you choose our office?**_____**Referred by**_____

Individual responsible for patient's account _____**Relationship to Patient** _____

Name of Vision Insurance Company Aetna / Cigna / Davis / EyeMed / Other _____

Member Name_____ **SSN or Member ID #** _____**Member Date of Birth** ____/____/____

Do you have any allergies to medications? Y N If yes, please list _____

List all medications, eye drops and supplements including over-the-counter medication: _____

Have you experienced any eye or medical conditions in the following areas? Check all that apply.

Eye Conditions: ☐Burning ☐Itching ☐Redness ☐Discharge ☐Dryness ☐Tearing ☐Flashes ☐Floaters ☐Stys ☐Double Vision ☐Eye Strain

Health Conditions:

☐Asthma	☐Sinus Congestion	☐Genitourinary	☐Weight Loss/Gain	☐Gastrointestinal	☐Vascular Disease	Pregnant Y○ N○
☐Anemia	☐Bronchitis	☐Muscle/Joint Pain	☐Headaches	☐Blood Disorder	☐Skin Condition	Nursing Y○ N○
☐Allergies/Hay Fever	☐Chronic Cough	☐Heart Pain	☐Migraines	☐ThyroidGlandular	☐Psychiatric	
	☐Emphysema	☐Seizures	☐Rheum. Arthritis	☐Recently given birth	☐MS	Other _____

Do you or your Family Members have any of the following conditions? **P =Patient F = Family member**

Lazy eye	☐P	☐F	Glaucoma	☐P	☐F	Macular Degen.	☐P	☐F	Diabetes	☐P	☐F
Eye Surgery	☐P	☐F	Blindness	☐P	☐F	Cancer	☐P	☐F	Retinal Detachment	☐P	☐F
Crossed Eye	☐P	☐F	Cataract	☐P	☐F	Color Blindness	☐P	☐F	High Blood Pressure	☐P	☐F

Other Health Issues, Surgeries and Hospitalizations: _____

Hours per day of computer use/day_____ When was your last eye exam? _____ Doctor Name? _____Were you dilated? Y○ N○

What hobbies or sports do you participate in? _____

Are you interested in LASIK? Y○N○ Do you currently wear contact lenses? Y○N○ Are you interested in wearing contact lenses? Y○ N○

Notice to Contact Lens Patients: The contact lens fitting/evaluation fee provides you with the diagnostic contact lenses needed for your contact lens prescription to be finalized. **Follow-up appointments related to your contact lenses in most cases are included in this fee for up to 45 days**. **Professional service fees, including the examination charges and contact lens fitting fee are non-refundable.**

Federal law mandates that contact lens prescriptions expire one year from the date of the fitting. Please Initial X_____

Informed Consent for Pupil Dilation and Screening Photography: Dilation is the standard of care when it comes to thoroughly evaluating the health of your eyes. Patients will notice increased light sensitivity and blurriness at near for the next 3-4 hours following dilation. We suggest you wear sunglasses. People usually do not have problems driving after pupil dilation. For patient education and documentation purposes, we also take retinal photographs of the important structures inside if your eyes. Photographs detect the progression of ocular disease more accurately than dilation alone. Photographs will be done on every patient unless instructed not to by initialing below.
Please Initial one…... I agree to both dilation and photos X _____ **I decline Photos X**_____ **I decline dilation X**_____

I understand that I may have co-payments, deductibles and overage costs and ultimately, I am responsible for all fees incurred. We do not guarantee the accuracy of benefit information provided by insurance companies

Patient Signature or Parent/Legal Guardian Signature if patient is a minor:

_____Date: _____