Welcome

Eyecare Center Of DuPage, Ltd.
Westmont, IL

So that we may provide you with the best possible care please complete both sides of this registration / medical history form. All information will be kept confidential. Thank you!

PATIENT INFORMATION

First Name_____ MI_____
Last Name_____
Address _____
Apt # / PO Box / Suite _____
City _____
State_____ Zip _____
Social Security # _____
Birthdate _____ ❑male ❑female

Home Phone (_____) _____ - _____
Work Phone (_____) _____ - _____
Cell Phone (_____) _____ - _____
e-Mail _____ @ _____
Employer Name _____
Address _____
City/ST/Zip _____
Occupation _____
Marital Status ❑single ❑married ❑other

RESPONSIBLE PARTY / GUARANTOR INFORMATION

Who is responsible for this account? ❑above patient (please skip to next section) ❑spouse ❑parent

Name _____
Employer _____
Address _____
City, State, Zip _____

Social Security # _____
Work Phone (_____) _____ - _____
Occupation _____
Birthdate _____

FAMILY INFORMATION

Please help us keep more accurate records by listing all members of your immediate family.

Name Age Patient Here? Y/N

_____
_____
_____
_____
_____

REFERRAL INFORMATION

Who referred you to our office?

Name _____

May we disclose your name in our thank you to the above person? ❑yes ❑no

If you were not referred to our office, how did you hear about us?

❑sign/location ❑phone book ❑insurance co.

Other _____

INSURANCE INFORMATION

Because you expect more, our office does not participate in reduced-fee vision plans.
In doing so we believe you will have a more satisfying experience in our office.
Please inform us if you have a vision plan.
Our **Direct File** program will assist you in receiving your vision plan benefits directly.

FINANCIAL POLICIES: Payment is required at the time services are rendered. A minimum 1/3 non-refundable deposit is required prior to ordering materials, with payment-in-full prior to dispense. Since eyeglasses and contact lenses are custom fabricated for you, orders once placed cannot be canceled and items cannot be returned for refund.

By my signature I certify the information I have provided is true. I understand the above policies and realize I am financially responsible for this account, regardless of any insurance coverage I may have. I agree to pay any collection costs, including reasonable attorney fees, should they be incurred. In the case of a minor patient, I certify I am the parent or legal guardian and consent to the treatment of said minor.

Signature of Responsible Party _____ Date _____

- OVER –

Visual & Medical History

Today's Date:

When was your last eye exam? _____ Doctor's Name & Address _____

If you wear glasses…

Does your spare pair have the current prescription? ……..❑yes ❑no
Do your prescription sunglasses have UV protection? ……..❑yes ❑no
Do you wear protective eyewear for sports or work? …….. ❑yes ❑no
Is the prescription in your computer glasses current? ……..❑yes ❑no
Are there certain times you'd rather not wear glasses? ……..❑yes ❑no

If you wear contact lenses…

Are you having ***any*** problems with your lenses? …….. ……❑yes ❑no
Are you interested in new contact lens technologies? ……❑yes ❑no
Do you obtain your lenses legally? ……❑yes ❑no
Are your back-up glasses the current prescription?..... ❑yes ❑no
Please rank the following from 1 – 5 in order of importance to you, 1 being most important and 5 being least important:

__vision __comfort __convenience __cost __health & safety

If you wear orthokeratology retainers …

Do you wear your retainers while you sleep? ❑yes ❑no Is your daytime vision without retainers clear? ❑yes ❑no

Please rate your level of computer use: ❑light ❑medium ❑heavy ***Any*** eyestrain? ❑yes ❑no

Medical History

Are you currently pregnant or nursing? ❑yes ❑no

Please list any allergies to medications: _____
Please list all medications you take: _____
List all major injuries, surgeries & hospitalizations: _____

Please check any of the following conditions that apply to you:

- ❑ Lazy eye
- ❑ Crossed-eyes
- ❑ Double vision
- ❑ Cataracts
- ❑ Glaucoma
- ❑ Retinal disease
- ❑ Macular degeneration
- ❑ Eye injury
- ❑ Eye infection
- ❑ Light sensitivity
- ❑ Poor night vision/glare
- ❑ See spots or flashes

Family History

Please indicate any family history (parents, grandparents, siblings, or children) for the following conditions:

- ❑ Blindness
- ❑ Cataract
- ❑ Crossed-eyes
- ❑ Glaucoma
- ❑ Macular degeneration
- ❑ Retinal detachment / disease
- ❑ Arthritis
- ❑ Cancer
- ❑ Diabetes
- ❑ Heart disease
- ❑ High blood pressure
- ❑ Kidney disease
- ❑ Lupus
- ❑ Thyroid disease
- ❑ Other _____

Social History

... this information is kept strictly confidential. However, you may discuss this directly with the doctor if you prefer.

Do you drive? ❑yes ❑no Are you having ***any*** visual difficulty when driving? ❑yes ❑no
Do you use tobacco products? ❑yes ❑no What type and how long? _____
Do you drink alcohol? ❑yes ❑no What type and how long? _____
Do you use illegal drugs? ❑yes ❑no What type and how long? _____
Have you ever been exposed to or infected with: ❑gonorrhea ❑hepatitis ❑HIV ❑syphilis

Review of Systems

Please check any conditions you have currently or have had previously:

CONSTITUTIONAL
- ❑ Fever, weight loss,/ gain

INTEGUMENTARY
- ❑ (Skin)

NEUROLOGICAL
- ❑ Headaches
- ❑ Migraines
- ❑ Seizures

EYES
- ❑ Vision loss
- ❑ Blurred vision
- ❑ Distorted vision / halos
- ❑ Loss of side vision
- ❑ Double vision
- ❑ Dry eyes
- ❑ Mucous discharge
- ❑ Redness
- ❑ Sandy / gritty feeling
- ❑ Itching
- ❑ Burning
- ❑ Foreign body sensation
- ❑ Excess tearing / watering
- ❑ Glare / light sensitivity
- ❑ Eye pain / soreness
- ❑ Chronic eye or lid infection
- ❑ Sties or chalazion
- ❑ Flashes / floaters in vision
- ❑ Tired eyes

ENDOCRINE
- ❑ Thyroid / other glands

EAR, NOSE, MOUTH, THROAT
- ❑ Allergies / hay fever
- ❑ Sinus congestion
- ❑ Runny nose
- ❑ Post-nasal drip
- ❑ Chronic cough
- ❑ Dry throat / mouth

RESPIRATORY
- ❑ Asthma
- ❑ Chronic bronchitis
- ❑ Emphysema

VASCULAR / CARDIOVASCULAR
- ❑ Diabetes
- ❑ Heart pain
- ❑ High blood pressure
- ❑ Vascular disease

GASTROINTESTINAL
- ❑ Diarrhea
- ❑ Constipation

GENITOURINARY
- ❑ Genitals / kidney / bladder

BONES / JOINTS / MUSCLES
- ❑ Rheumatoid arthritis
- ❑ Muscle pain
- ❑ Joint pain

LYMPHATIC / HEMATOLOGIC
- ❑ Anemia
- ❑ Bleeding problems
- ❑ ALLERGIC / IMMUNOLOGIC ❑
- PSYCHIATRIC ❑

OFFICE USE ONLY Doctor's Signature Date