Iconic Eyes Optometry

Please fill out your health history below and review the information we have is current and accurate

☐ Male ☐ Female ☐ Nonbinary

First Name | MI | Last Name | Preferred Name

Street Address | City | State | Zip

New Patients: Last 4 SSN or ID # | Date of Birth | Preferred Phone # ☐ cell | Email Address

How did you find out about our office?

Guardian

INSURANCE INFORMATION

Vision Insurance

Insured's First Name | Insured's Last Name | Insured's last 4 SSN or ID #

Insured's DOB

Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

PATIENT HISTORY AND INFORMATION

☐ **established patient, no changes**

☐ **Unknown Family History**

Primary Care Physician / Clinic Name

What is the main reason for today's exam ?

Last eye exam ? Last health exam ?

Occupation Hobbies

Current Medications:

Current Eye Drops:

Specific Allergies:

Do you currently wear glasses ? ○ Yes ○ No

How many hours of screentime a day (computer/phone) ?

Do you currently wear contact lenses? ○ Yes ○ No

Type and brand of contact lenses

Are you pregnant? ○ Yes ○ No Are you nursing? ○ Yes ○ No Do you smoke ? ○ Yes ○ No

PERSONAL EYE SYMPTOMS

Blurred Vision Distance ☐	Watery Eyes ☐	Glaucoma ☐ ☐	Diabetes ☐ ☐
Blurred Vision Near ☐	Redness ☐	Cataract ☐ ☐	High Blood Pressure ☐ ☐
Fluctuating Vision ☐	Eye Infections ☐	Macular Degeneration ☐ ☐	High Cholesterol ☐ ☐
Eyestrain / Headaches ☐	Glare/Light Sensitivity ☐	Retinal Detachment ☐ ☐	Heart Disease ☐ ☐
Itchy Eyes ☐	Double Vision ☐	Amblyopia (Lazy Eye) ☐ ☐	Thyroid Disease ☐ ☐
Dry Eyes ☐	Floaters / Flashes ☐	Strabismus (Cross Eye) ☐ ☐	Seasonal Allergies ☐ ☐
Eye Allergies ☐	Color Blindness ☐	Eye Surgery/Trauma ☐ ☐	Cancer ☐ ☐
			Other ☐ ☐

EYE DISEASES	Self	Family
Glaucoma	☐	☐
Cataract	☐	☐
Macular Degeneration	☐	☐
Retinal Detachment	☐	☐
Amblyopia (Lazy Eye)	☐	☐
Strabismus (Cross Eye)	☐	☐
Eye Surgery/Trauma	☐	☐

HEALTH	Self	Family
Diabetes	☐	☐
High Blood Pressure	☐	☐
High Cholesterol	☐	☐
Heart Disease	☐	☐
Thyroid Disease	☐	☐
Seasonal Allergies	☐	☐
Cancer	☐	☐
Other	☐	☐

Please Read: Billing / HIPPA Confidentiality

In order to control the cost of billing, the patient's portion is paid at the time services. All professional services and materials are charged to the patient.There will be a service charge of $25 on all returned checks.

I understand that will be billed as my primary insurance. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

I give Iconic Eyes Optometry my consent to use or disclose my protected health information (such as DOB, last 4 SSN) to obtain payment from insurance companies, to view my past prescription histories, and for healthcare operations like quality review.

I understand that I am responsible for service fees not covered by my insurance. If contact lens evaluations are not covered by insurance, the fees are $60 for standard, $80 for astigmatism,$100for multifocal/monovision, and $120 for RGP evaluations. The fee include up to 3 months of contact lens trial follow-up visits. If not covered by insurance, comprehensive exam with vision test is $118, intermediate office visit is $85.

Iconic Eyes Optometry will not sell any personal information to any third parties. I understand that I may revoke this consent at any time, making a request in writing, except for the information already used or disclosed.

Signature | Date