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 _____

Guardian _____ How did you find out about our office? _____

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**

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 ☐
Blurred Vision Near ☐	Redness ☐
Fluctuating Vision ☐	Eye Infections ☐
Eyestrain / Headaches ☐	Glare/Light Sensitivity ☐
Itchy Eyes ☐	Double Vision ☐
Dry Eyes ☐	Floaters / Flashes ☐
Eye Allergies ☐	Color Blindness ☐

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.

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 _____