Welcome to ANCALA EYE CARE, P.C.

Name: ______________________________________ Date of Birth: ______________________________
(Last) (First) (M.I.)

Address: ______________________________________ Home Phone: (   )____________________________

______________________________________ Daytime Phone: (   ) ______________________
City State Zip

Cell Phone: (   ) ____________________________ E-mail: ___________________________________

Occupation: __________________________________

It is important to know how you use your eyes, so please tell us about any hobbies you might have and how many hours you work at the computer: ____

____

Do you belong to any Insurance Plan that covers eye exams or glasses? Yes/No

Name of Plan: _________________________________ Employer: _________________________________

REASON FOR TODAY'S EXAM:____

A thorough eye exam allows us to evaluate your ocular health and muscles, which can reveal other general health problems such as high blood pressure and diabetes. Please indicate whether you or anyone in your family has any of these conditions (Past or Present)

	Self/family		Self/family		Self/family
Diabetes	❑ / ❑	Arthritis	❑ / ❑	Tumors/Cancer	❑ / ❑
High Blood Pressure	❑ / ❑	Headaches	❑ / ❑	Thyroid	❑ / ❑
Dry Skin	❑ / ❑	Dry Eyes	❑ / ❑	Heart Disease	❑ / ❑
Sinus	❑ / ❑	Seasonal Allergies	❑ / ❑	Other _______________	❑ / ❑
Asthma	❑ / ❑	Lupus	❑ / ❑		

Some eye diseases are hereditary, passed on from generation to generation, like retinitis pigmentosa and glaucoma. It is important to know this before the exam:

	Self/family		Self/family		Self/family
Glaucoma	❑ / ❑	Amblyopia (Lazy eye)	❑ / ❑	Cataracts	❑ / ❑
Blindness	❑ / ❑	Strabismus (Crossed eyes)	❑ / ❑	Other _______________	❑ / ❑
Retinal Detachment	❑ / ❑	Macular Degeneration	❑ / ❑	Eye Surgery __________	❑ / ❑

Date of last eye exam :____________________________ Name of Dr.: __________________________
(Month/Year)

Name of family physician: ____

It is imperative to know what medications you are taking because many can affect your eyes; antihistamines and birth control pills for example cause drying of your eyes and glands. Please list prescription and non-prescription medications including vitamins, nasal sprays, and over the counter medications:

____

List any Drug allergies: ____

Do you now wear or have ever worn: Glasses? Yes/No Sunglasses? Yes/No Contact Lenses? Yes/No

If you had difficulties with contact lenses in the past, what was the problem? _____________________________

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How did you hear about our office?

Referred by: Friend/Co-Worker _____________ Yellow Pages ___________ Vision Plan _________ Other________

Office policy requires payment at the time our services are provided. For all returned checks, a $20.00 service charge will be assessed. Any outstanding balance over 60 days will be subject to Finance charges.

I authorize Ancala Eye Care, P.C. to release any information required to my insurance carrier to process this claim. I also acknowledge that I am financially responsible for all non-covered charges.

____ ________________
(Responsible Party) (Date)