

WELCOME TO THE DOMIANO EYE CARE CENTER

(Please Print) _____ Date _____

Patient _____ Age _____ Date of Birth _____

Home Address _____ City _____ Zip _____

Home Phone () _____ Cell Phone () _____

Employer _____ Occupation _____

Business Address _____ Business Phone () _____

SS# _____ E-Mail ** _____

Spouse's Name _____ Employer _____

Business Phone _____ Referred By _____

** Due to medical privacy laws, we will not share this with anyone. **

MEDICAL HISTORY

Date of last vision exam _____ Previous Eye Doctor _____

Past injury or surgery to eyes? Yes No Please Describe: _____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury? _____

Have you had a physical exam in the last 12 months? Yes No Physician's Name _____

Please describe if there were any significant findings _____

List any medications you are taking, reason, and start date _____

Are you allergic to any medications? If yes, please list _____

Do you drive? No Yes Do you have visual difficulty when driving? No Yes If yes please describe: _____

Please list an emergency contact who is not living with you:

Name: _____ Phone: _____ Relationship: _____

FAMILY and HEALTH HISTORY

Please note any personal or family history (parents, grandparents, siblings; living or deceased) for the following conditions:

CONDITION	YES	NO	Details	RELATIONSHIP TO YOU
Blindness				
Cataracts				
Crossed Eyes				
Glaucoma				
Macular Degeneration				
Retinal Detachment/Disease				
Cancer (list type)				
CONDITION	YES	NO		RELATIONSHIP TO YOU

Accident/Head Trauma (list type, year)			
CARDIOVASCULAR: (high blood pressure, hypercholesterolemia, etc.)			
NEUROLOGICAL (Stroke, aneurysm, numbness, headache, seizures, neurosurgery, paralysis, etc.)			
ENDOCRINE (diabetes, hypothyroid, hyperthyroid, etc.)			
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			
SKIN (cancer, rosacea, dryness, eczema, psoriasis, growths, rash, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
RESPIRATORY (congestion, wheezing, shortness of breath, etc.)			
GASTROINTESTINAL (Crohn's, ulcers, hernia, etc.)			
BLOOD/ LYMPH (bleeding, anemia, problems related to blood transfusion, etc.)			
GENITAL, KIDNEY, BLADDER (painful or frequent urination, kidney disease, yellow jaundice, etc.)			
FEMALES: Are you pregnant or nursing?			
MUSCLES, BONES, JOINTS (arthritis, joint pain, swelling, cramps, etc.)			
EARS, NOSE, THROAT (hard of hearing, dry mouth, etc.)			
Smoking tobacco			
Other			

ACCOUNT RESPONSIBLE

Payment is expected when services are rendered, unless other arrangements are made in advance.

There is a 1½ % monthly service charge for balances after 30 days. The patient is responsible for any legal and related expenses involved in the collection of past due accounts.

Credits on materials are issued as store credits only. There are no credits on custom or prescription items. There is a restocking fee for any returned materials. There is a charge for additional tests and contact lens evaluation.

There is a \$35.00 late cancellation fee for appointments that are changed or canceled within 24 hours of your appointment time.

Method of payment: Self Parent

Vision Insurance company and group number: _____

Name, Date of birth, and Social Security number for Primary Insured: _____

Signature of person responsible for payment: _____ Date: _____

Please bring form with you to your appointment. Thank You