Kas Eye Center

www.kaseyecenter.com

WELCOME!

PERSONAL INFORMATION

Name: _____ Sex: ☐M ☐F Date of Birth: ____/____/_____ Age: _____
(*LAST*) (*FIRST*)

Address: _____
Street *City* *State* *Zip*

Cell Phone: (____)_____ 2nd Phone: (____)_____ Social Security #: ____-____-_____

Employer: _____ Occupation: _____ E-Mail: _____

INSURANCES

VISION INSURANCE:

Circle all that apply: VSP, MES, EyeMed, Spectera, Delta, Safeguard, Superior, Tricare, Others: _____

Member Name: _____ DOB: ____/____/____ SS#: _____ Relationship to Pt: _____

MEDICAL INSURANCE: *(All medically related eye visits are billed to your **Medical** Insurance)*
Circle all that apply: Blue Cross/Shields, Medi-Care, Kaiser, Pacific Care, Cigna, Aetna, United Health, Others: _____

Member Name: _____ DOB: ____/____/____ SS#: _____ Relationship to Pt: _____

WHAT IS THE REASON FOR TODAY'S VISIT? (Check all that apply)

☐ I have an **Eye Disease or Eye Problem** requiring examination: _____

☐ I want **Glasses:** Age of present glasses: _____
Is there a time when your glasses get in the way of your activities? ☐Y ☐N When? _____
Would you like to try (for free) a pair of contact lenses today? ☐Y ☐N

☐ I want **Contact Lenses:** ☐Clear ☐Colored Brand? _____ Solution? _____
First time trying contact lenses? ☐Y ☐N

☐ I am interested in a non-surgical way to see clearly (**Orthokeratology**). No glasses or contacts during the day and it helps your eyes from getting worse. (Good for ALL ages)

DO YOU EXPERIENCE ANY OF THE FOLLOWING? (Check all that apply)

☐ Distance vision blurred w/ glasses	☐ Dry/ Burning eyes	☐ See flashing lights
☐ Near vision blurred w/ glasses	☐ Watery eyes	☐ See floaters or spots
☐ Headaches related to eyes	☐ Itchy eyes	☐ Double Vision
☐ Eye strain	☐ Red eyes	☐ Sensitivity to lights

MEDICAL AND EYE HISTORY (Check all that apply to you or your immediate family)

Last Eye Exam _____ **Where?** _____ **Last Physical Exam** _____ **Where?** _____

	Self	Family		Self	Family		Self	Family
Diabetes	☐	☐	Asthma	☐	☐	Glaucoma	☐	☐
High Blood Pressure	☐	☐	Thyroid Problems	☐	☐	Cataracts	☐	☐
Heart Condition	☐	☐	Sinus Problems	☐	☐	Lazy/Cross Eye	☐	☐
Cholesterol Problems	☐	☐	Cancer	☐	☐	Retinal Disease	☐	☐

Are you pregnant? (if applicable) ☐Y ☐N
Are you currently taking any medication? ☐Y ☐N If yes, please list: _____
Are you allergic to any medication? ☐Y ☐N If yes, please list: _____
Have you had any eye surgery or injury? ☐Y ☐N If yes, please explain: _____

Who may we thank for kindly referring you to our office? _____

_____ _____
PATIENT SIGNATURE (If under 18, parent signature required) DATE

THANK YOU!