Kofos Family Eye Care
Welcome To Our Office

Welcome to Kofos Family Eye Care. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you place in us. Please take a moment to review and complete the following information. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name ____ MI ____ Last Name ____ Preferred Name ____

Street Address ____ City ____ State ____ Zip ____

Date of Birth ____ Home Phone (with area code) ____ ☐ Day Phone ☐ Cell Number ____

Email Address ____ Guardian ____ Person Responsible for Account ____

Emergency Contact ____ Emergency Phone ____

Patient Relationship to Insured
☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status ☐ Single ☐ Married ☐ Other
☐Full Time Student ☐Part time Student ☐Employed
☐ Retired

PRIMARY HEALTH INSURANCE INFORMATION

Name and Address of Primary Insurance Company ____ City ____ State ____ Zip ____

M ☐ F☐ Insured's First Name ____ MI ____ Insured's Last Name ____

Insured's Identification Number ____ Group Number ____ Insured's Date of Birth ____

SECONDARY HEALTH INSURANCE INFORMATION / SECONDARY VISION PLAN

Name of Secondary Insurance or Vision plan ____

M ☐ F☐ Insured's First Name ____ MI ____ Insured's Last Name ____

Insured's Identification Number ____ Group Number ____ Insured's Date of Birth ____

Please Read:

We ask that the patient's portion is paid at the time of services rendered unless other arrangements are made in advance. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

I understand that all benefits quoted to me by this office or my insurance companies are not a guarantee of payment by my insurance companies and that final determination can only be made when the claims are processed.

Signature ____ Date ____

Race

☐ American Indian or Alaska Native ☐ Other Race ☐ Refuse to Specify
☐ Asian ☐ White ☐ Not Disclosed
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ Other Race: ____________________

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Preferred Language: ☐ English ☐ Spanish ☐ French ☐ Italian ☐ Russian ☐ Portuguese

Height	Feet	Inches

Weight		Pounds

PRIMARY CARE PHYSICIAN

____
Primary Care Physician and Clinic Name
____

REFERRING PHYSICIAN

____
Referring Physician and Clinic Name
____

HEALTH HISTORY

What is the main reason for today's vision exam?___________________When was your last eye exam?_____________
When was your last health exam?_______________________________

Current Illnesses or Injuries: ______________________ ______________________
______________________ ______________________
______________________ ______________________

Past Surgeries: ______________________ ______________________
______________________ ______________________

Current Medications: ______________________ ______________________
☐ *Check if separate list attached* ______________________ ______________________
______________________ ______________________

Current Eye Drops: ______________________ ______________________
______________________ ______________________

Medicines that cause reactions or sensitivities:____

Specific Allergies: ____

EYE HISTORY:

Condition			Condition			Condition		
Glaucoma	○ Yes	○ No	Dryness	○ Yes	○ No	Strabismus (Crossed Eyes)	○ Yes	○ No
Cataract	○ Yes	○ No	Excess Tearing/Watering	○ Yes	○ No	Blurred Vision Distance	○ Yes	○ No
Macular Degeneration	○ Yes	○ No	Eye Pain or Soreness	○ Yes	○ No	Blurred Vision Near	○ Yes	○ No
Retinal Detachment	○ Yes	○ No	Foreign Body Sensation	○ Yes	○ No	Distorted Vision (halos)	○ Yes	○ No
Color Blindness	○ Yes	○ No	Infection of Eye or Lid	○ Yes	○ No	Double Vision	○ Yes	○ No
Headaches	○ Yes	○ No	Itching	○ Yes	○ No	Floaters or Spots	○ Yes	○ No
Glare/Light Sensitivity	○ Yes	○ No	Mucous Discharge	○ Yes	○ No	Fluctuating Vision	○ Yes	○ No
Tired Eyes	○ Yes	○ No	Drooping Eyelid	○ Yes	○ No	Loss of Vision	○ Yes	○ No
Amblyopia (Lazy Eye)	○ Yes	○ No	Redness	○ Yes	○ No	Loss of Side Vision	○ Yes	○ No
Burning	○ Yes	○ No	Sandy or Gritty Feeling	○ Yes	○ No			

GENERAL HEALTH CONDITION/HISTORY

Fever	O Yes O No	Respiratory (i.e., Asthma)	O Yes O No	Anxiety or Depression	O Yes O No
Weight Loss	O Yes O No	Gastrointestinal	O Yes O No	Thyroid, Diabetes	O Yes O No
Other Symptoms	O Yes O No	Kidney	O Yes O No	Blood/Lymph	O Yes O No
Ears, Nose, Throat	O Yes O No	Muscle, Bones, Joints	O Yes O No	Allergic	O Yes O No
Cardiovascular (High	O Yes O No	Skin	O Yes O No		
Blood Pressure, etc.)		Neurological (i.e., MS)	O Yes O No	Are you?	Pregnant
			O Yes O No		Nursing

FAMILY HISTORY

Amblyopia (Lazy Eye)	O Yes O No	Retinal Detachment	O Yes O No	High Blood Pressure	O Yes O No
Blindness	O Yes O No	Strabismus (Eye Turn)	O Yes O No	Kidney Disease	O Yes O No
Cataract(s)	O Yes O No	Arthritis	O Yes O No	Lupus	O Yes O No
Color Blindness	O Yes O No	Cancer	O Yes O No	Stroke	O Yes O No
Glaucoma	O Yes O No	Diabetes	O Yes O No	Thyroid Disease	O Yes O No
Macular Degeneration	O Yes O No	Heart Disease	O Yes O No	Others	O Yes O No

SOCIAL HISTORY

Current Occupation:___________________________ Years_____________ Employer______________________________________

Do you use nutritional supplements (vitamins, etc.)? O Yes O No

Do you engage in regular exercise? O Yes O No

Do you drink alcohol? How often? O No O Occasional O 1 Per Day O 1-2/Day O 4+/Day

Do you smoke? How often? O No O Occasional O ½ Pack/Day O 1 Pack/Day O 1+ Pack/Day

Method of Tobacco Intake O Smoking O Chewing

Do you use illegal drugs? O Yes O No

Do you use a computer? O Yes O No

Do you drive? O Yes O No Mileage per day?____________________

Do you have glare problems? O Yes O No

Do you have visual difficulty when driving? O Yes O No

Do you have problems with night vision? O Yes O No

Do you currently wear glasses? O Yes O No

Type of glasses: O Full Time O Part Time O Distance O Close

Do you wear Sunglasses? O Yes O No If yes, are they prescription? O Yes O No

CONTACT LENSE HISTORY

Do you currently wear contact lenses? O Yes O No

Have you ever tried to wear contact lenses? O Yes O No Reason for stopping?______________________

If not a contact lens wearer, are you interested in trying contact lenses at this time? O Yes O No