Radiant
OPTOMETRY

Optimal Vision, Optimal Health

PATIENT INFORMATION

Date ____/____/_____

Patient Name (Last, First) _____☐M ☐F DOB _____/_____/_____ Age _____

Address _____ City _____ State:____ Zip Code _____

Social Security # __ __ __-__ __-__ __ __ __ Employer _____ Occupation_____

Home Phone (____)_____-_____ Cell Phone (____)_____-_____ Email: _____

Primary Insurer Name _____ DOB ___/___/____ Relationship to patient_____

Social Security # __ __ __-__ __-__ __ __ __

How did you hear about us? ☐Facebook ☐Instagram ☐Yelp ☐Google ☐Referred by _____

EYE HEALTH HISTORY

Last Eye Exam ☐ 1 year ☐ 2 years ☐ ____ years Name of Doctor/Location _____

Any eye diseases, injuries, or surgeries in the past ☐Yes ☐No If Yes, when _____

Do you wear Glasses? ☐Yes ☐No How often? ☐All the time ☐Occasionally ☐Reading ☐Driving ☐TV

Do you wear Contacts? ☐Yes ☐No ☐Soft ☐Hard ☐Sphere ☐Toric ☐ Multifocal

☐Daily ☐Bi-weekly ☐Monthly ☐Brand _____

☐Hours of contact lens wear per day _____

Any problems you have with your contacts?

☐Dryness ☐Rips Easily ☐Uncomfortable by the end of the day ☐Other _____

Are you interested in Vision Correction through Contact Lens? ☐YES! ☐No

Please check all symptoms you are currently experiencing:

☐Blurry Vision-Distance ☐Dryness/Sandy ☐Eyestrain ☐Headaches ☐Flashes

☐Blurry Vision-Near ☐Itchy Eyes ☐Pain/Soreness ☐Light Sensitivity ☐Floaters

☐Double Vision ☐Watery ☐Redness ☐Discharge ☐Other_____

MEDICAL HEALTH HISTORY

Name of Primary Care Physician _____ Date of Last Physical Exam_____

Do YOU or any BLOOD RELATIVES have any of the following conditions?

	Self	Relatives		Self	Relatives		Self	Relatives
AIDS/ HIV	☐	☐	Chemical dependency	☐	☐	Pacemaker/ heart surgery	☐	☐
Arthritis	☐	☐	Diabetes	☐	☐	Retinal disease	☐	☐
Artificial heart valve	☐	☐	Emphysema	☐	☐	Rheumatic fever	☐	☐
Artificial Joints	☐	☐	Hepatitis	☐	☐	Shingles	☐	☐
Asthma	☐	☐	Kidney disease	☐	☐	Skin conditions	☐	☐
Blood disease	☐	☐	Lupus	☐	☐	Stroke	☐	☐
Cancer	☐	☐	Migraines/ headaches	☐	☐	Thyroid conditions	☐	☐
						Tuberculosis	☐	☐

Please list medications you are currently taking, including eye drops
MEDICATIONS

_____

_____

Please list your allergies to medications or other substances:
ALLERGIES

_____

_____

SOCIAL HISTORY

Do you play any sports? ☐No ☐Yes _____ Do you have any hobbies? ☐No ☐Yes _____

Hours spent on _____☐TV _____☐Reading per day

_____☐Computer _____☐Playing/working outside

_____☐Video games

Do you (check all that apply) ☐Smoke ☐Drink ☐Drugs

INSURANCE

Person responsible for account _____
Last Name First Name Middle Initial

Insurance Company Name: _____ Member ID # _____

Relation to Patient: _____ Member's DOB _____/_____/_____

Member's Social Security # _____-____-_____

ASSIGNMENT AND RELEASE

I certify that, I and/or my dependents (s), have insurance coverage with _____(name of insurance) and assign directly to Radiant Optometry all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient|Parent|Guardian|Personal Representative Date

_____ _____
Please Print Name of Patient|Parent|Guardian|Personal Representative Date