Guardian: ______________ **Date.**

Name: ______________

Address: ______________

City, St: ______________ **Zip:** ______________

Phone(Cell): ______________ H: ______________ W: ______________

Date of Birth: ______________ Sex: ______________

E-Mail: ______________

Occupation: ______________

Notify me by: ☐ Text ☐ Phone ☐ Email ☐ Mail

Who may we thank for referring you to our office?

☐ Friend ☐ Insurance ☐ Phone Book ☐ Other…

Acuity Eye Care

2669 Union Lake Rd.
Commerce Township, MI 48382
248-360-4300
Fax- (248)716-9946
E-mail: egayeyecare@gmail.com
http://www.acuityeyecaremi.com

Race
- ◯ American Indian or Alaska Native
- ◯ Asian
- ◯ Black or African-American
- ◯ Native Hawaiian or Other Pacific Islander
- ◯ Other Race
- ◯ Unknown/undetermined
- ◯ White

Ethnicity
- ◯ Not Hispanic or Latino 2186-5
- ◯ Hispanic or Latino 2135-2

Language ☐ English ☐ French ☐ Mandarin ☐ Other… ☐ Spanish ☐ Japanese ☐ Unknown

Smoking
- ◯ Ex-smoker
- ◯ Never smoked tobacco
- ◯ Heavy tobacco smoker
- ◯ Light tobacco smoker
- ◯ Tobacco Smoking Consumption unknown

Emergency Contact Name and Phone: ______________

Approx. Date of Last Eye Exam: ______________

What is the major purpose of this visit:

- ☐ Blur at Far
- ☐ Blur at Near
- ☐ Blur at Far & Near
- ☐ Itching
- ☐ Burning
- ☐ Redness
- ☐ Eye pain
- ☐ Eye strain
- ☐ Flashes/Floaters
- ☐ Loss of vision
- ☐ Double vision
- ☐ Sandy/Gritty
- ☐ Spots or shadows
- ☐ Diabetes eye check
- ☐ Medical eye check
- ☐ Other…

Which Eye? ☐ Right eye ☐ Left eye ☐ Both eyes

How long has it bothered you?

- ☐ Started today
- ☐ 1-2 days
- ☐ 3-7 days
- ☐ 1-2 weeks
- ☐ 2-4 weeks
- ☐ 1-3 months
- ☐ 3-6 months
- ☐ Over 6 months

Severity? ☐ Mild ☐ Moderate ☐ Severe

Getting Worse?

☐ Getting better ☐ Getting worse ☐ About the same

Current Prescription:

Glasses: Right ______________

Left ______________

Contacts: Right ______________

Left ______________

Medical Doctor(s):

Please note that insurance does NOT cover the Contact Lens Fitting Evaluation

Vision or Primary Insurance

Ins. Name: ______________

Ins Number: ______________

Relationship: ______________

Insured: ______________

Insured DOB: ______________ **Ins. Sex:** ◯ M ◯ F

Co-pay: ______________ **Materials:** ◯ Y ◯ N

Medical or Secondary Insurance

Ins. Name: ______________

Ins Number: ______________

Relationship: ______________

Insured: ______________

Insured DOB: ______________ **Ins. Sex:** ◯ M ◯ F

Co-pay: ______________ **Materials:** ◯ Y ◯ N

Do you have a flex spending or health savings account? ☐ Y ☐ N

Past Medical History

- ☐ Allergy
- ☐ Amblyopia
- ☐ Asthma
- ☐ Cataract
- ☐ Crossed Eyes
- ☐ Diabetes 1
- ☐ Diabetes 2
- ☐ Droopy Lid
- ☐ Ear
- ☐ Eye Infection
- ☐ Eye Injury
- ☐ Glaucoma
- ☐ Heart disease
- ☐ High B.P.
- ☐ Keratoconus
- ☐ Kidney
- ☐ Lasik
- ☐ Macular Degen.
- ☐ Melanoma
- ☐ Migraine
- ☐ Respiratory
- ☐ Sinusitis
- ☐ Stye
- ☐ Thyroid
- ☐ Other…

Eye wear History

- ☐ Glasses
- ☐ Bifocals
- ☐ Trifocals
- ☐ No- line
- ☐ Soft Contacts
- ☐ Toric Soft
- ☐ Gas Perm
- ☐ Hard
- ☐ Monovision
- ☐ Disposable
- ☐ Overnight wear

Mark box if yes.

- ☐ Have you tried contact lenses?
- ☐ Not satisfied with the vision comfort of contacts?
- ☐ Would you prefer colored contacts?
- ☐ Do the bifocal's lines and head tilting bother you?

Drug Allergies

- ☐ None
- ☐ Penicillin
- ☐ Sulfa
- ☐ Eye drops
- ☐ Other…

Social History

- ☐ Computer
- ☐ Reading
- ☐ Student
- ☐ Music
- ☐ Skiing
- ☐ Golf
- ☐ Fishing
- ☐ Tennis
- ☐ Swim
- ☐ Bike
- ☐ Drug Abuse
- ☐ Alcohol Abuse
- ☐ No alcohol or drug abuse
- ☐ Other…

Current Medicines	Amount

Family History

- ☐ Blindness
- ☐ Cancer
- ☐ Crossed Eyes
- ☐ Color Blind
- ☐ Diabetes 1
- ☐ Diabetes II
- ☐ Kidney
- ☐ Macular Degen.
- ☐ Retina Detach
- ☐ Heart Disease
- ☐ High B.P.
- ☐ Thyroid
- ☐ Glaucoma
- ☐ None
- ☐ Other…

Lifestyle Questions

Do you...(Check box if your answer is yes)

- ☐ Work at a computer often?
- ☐ Think you might benefit from thinner lenses?
- ☐ Would like to "test drive" the latest contact lenses?
- ☐ Spend time outdoors?
- ☐ Prefer not to wear your glasses at times?
- ☐ Want info. on Laser Vision Correction surgery?
- ☐ Have more than 1 pair of current Rx eyewear?

I, the undersigned, certify I (or my dependent) have insurance with the provided insurance companies and assign directly to FPO, PLLC (herein referred to as Acuity Eye Care) all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all changes whether or not paid by insurance. I authorize the use of this signature on all insurance submissions. If for any reason insurance does not pay the amount contracted I will be responsible for the balance owing. **Contact lens fit and follow up care is billed separately from your eye exam.** Your information is protected by our privacy policy. *I have received a copy of* Acuity Eye Care *"Notice of Privacy Practices".*

Remind me of my appointment by: ☐ Text

Signature________________________________ Date_____________

Relationship to Patient: ______________________________________

Exam:
____ Dilating ____Photos ____ Auto Refraction/Keratometry ____ Topography ____ Visual Fields

Glasses:
____ Frame Style/Disp. ____ Repair ____ PAL ____ Poly ____ AR ____ Trans ____ Sunglasses ____ Readers ____ Computer

Contacts:
____ I&R ____ Polish

Schedule:
____ VA ____ LASIK ____ Visual Fields ____ Photos ____ Dilation ____ IOP ____ Punctal Plugs ____ CLE ____ VT Instructionl

MISC:
Records Release Checkout