Arnett Eye Center 317-486-9427

Guardian: _____ **Date:**

Name: _____ _____

Address: _____

City, St: _____ **Zip:** _____

Phone(H): _____ **(C):** _____

Date of Birth: _____ **Sex:** ____

Vision or Primary Insurance

Ins.: _____ **#:** _____

Insured: _____ **DOB:** _____

Relationship:

Medical or Secondary Insurance

Ins.: _____ **#:** _____

Insured: _____ **DOB:** _____

Relationship:

E-Mail: _____

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

Referred by (name of friend we can thank)

☐ Friend ☐ Insurance ☐ Phone Book ☐ Other...

Medical Doctor(s):

Approx. Date of Last Eye Exam:

Glasses R-

L-

Contacts R-

L-

Allergies

☐ None
☐ Penicillin
☐ Sulfa
☐ Eye drops
☐ Other...

Current Medicines

Race **Ethnicity** **Language**

History or Problems

☐ Allergy	☐ Eye Infection	☐ Lazy Eye
☐ Amblyopia	☐ Eye Injury	☐ Macular Degen.
☐ Asthma	☐ Eye Surgery	☐ Migraine
☐ Cancer	☐ Gastrointestinal	☐ MS
☐ Cataract	☐ Glaucoma	☐ Psychological
☐ Crossed Eyes	☐ Heart	☐ Sinus
☐ Diabetes I	☐ High B.P.	☐ Thyroid
☐ Diabetes II	☐ Keratoconus	☐ Other...
☐ Droopy Lid	☐ Kidney	
☐ Ear Problem	☐ Lasik	

Clear

Eye wear History (have you ever worn...)

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

Family History (parents, grandparents, siblings)

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

Social History

☐ Computer	☐ Skiing	☐ Swim
☐ Reading	☐ Golf	☐ Bike
☐ Student	☐ Fishing	☐ Drug Abuse
☐ Music	☐ Tennis	☐ Alcohol Abuse

Occupation

☐ No alcohol or drug abuse
☐ Other...

☐ 1 Current everyday smoker
☐ 2 Current some day smoker
☐ 3 Former smoker
☐ 4 Never smoker
☐ 5 Smoker, current status unknown
☐ 9 Unknown if ever smoked

Current eye problem(s) (please circle the "main" problem)

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

☐ Right eye ☐ Left eye ☐ Both eyes

☐ Mild ☐ Moderate ☐ Severe

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

☐ Getting better ☐ Getting worse ☐ About the same

Are you interested in contact lenses information?

☐ Try Contacts ☐ Upgrade Contacts ☐ No interest in Contacts

Our office requires payment at the time of service unless payment arrangements have been approved in advance by our office staff. We will be happy to file for insurance reimbursement; however, any monies remaining owed beyond this will be due from you, as the financial responsibility for your visit is ultimately yours. A charge will be added to accounts 30 days past due; failure to pay balances in the allotted time will result in additional collection fees. We require a 24 hour cancellation notice; accordingly, we will charge for appointments not canceled 24 hours in advance. Contact lens fittings and follow up care are billed separately from your Routine Eye Exam. Special testing is not considered routine care and will be billed through major medical insurance. A copy of "Notice of Privacy Practices" is available at your request.

Relationship to Patient _____ Signature_____ Date_____

Signed