Guardian: __________ **Date:** __________

Name: __________

Address: __________

City, St: __________ **Zip:** __________

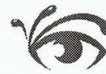
Phone(H): __________ W: __________ C: __________

Date of Birth: __________ Sex: __________

E-Mail: __________

Occupation: __________

Contact me by: ☐ Phone ☐ Email ☐ Mail



Dr. W. Eric Jones

314 Fountains Pkwy, Ste D
Fairview Heights IL, 62208
618-622-3013
Fax- 618-622-3014
E-mail: info@fountainseyecare.com
http://www.fountainseyecare.com

Who may we thank for referring you to our office?

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

____

Emergency Contact Name and Phone:

____

Last Eye Exam: __________

What is the major purpose of this visit:

- ☐ Blur at Far
- ☐ Blur at Near
- ☐ Blur at Far & Near
- ☐ Red eye
- ☐ Itching
- ☐ Burning
- ☐ Redness
- ☐ Eye pain
- ☐ Eye strain
- ☐ Flashes/Floaters
- ☐ Loss of vision
- ☐ Loss of side vision
- ☐ Double vision
- ☐ Sandy/Gritty Feeling
- ☐ Foreign Body Sensation
- ☐ 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 ☐ Worse AM ☐ Worse PM

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

Primary Insurance

Ins. Name: __________

Ins Number: __________

Relationship: __________

Insured: __________

Insured DOB: __________ Ins. Sex: ○ M ○ F

Co-pay: __________ Materials: ○ Y ○ N

Secondary Insurance

Ins. Name: __________

Ins Number: __________

Relationship: __________

Insured: __________

Insured DOB: __________ Ins. Sex: ○ M ○ F

Co-pay: __________ Materials: ○ Y ○ N

Do you participate in a flex spending account?

☐ Y ☐ N

How will you settle your account today?

☐ Cash ☐ Check ☐ Credit Card

Current Prescription:

Glasses: Right __________

Left __________

Contacts: Right __________

Left __________

Medical Doctor(s):

Past Medical History

- ☐ Ambylopia
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune
- ☐ Cancer
- ☐ Cataract
- ☐ Crossed eyes
- ☐ Diabetes
- ☐ Droopy lid
- ☐ Ear/Nose
- ☐ Eye infections
- ☐ Eye injuries
- ☐ Eye Surgery
- ☐ Gastrointestinal
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ High B.P.
- ☐ Keratoconus
- ☐ Kidney
- ☐ LASIK
- ☐ Lazy eye
- ☐ Lupus
- ☐ Macular Degen.
- ☐ Migraine
- ☐ MS
- ☐ Neurological
- ☐ Psychological
- ☐ Respiratory
- ☐ Sinus
- ☐ 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 your contact lenses?
- ☐ Would prefer colored contacts?
- ☐ Do the lines and head tilting bother you with bifocals?

Allergies

- ☐ None
- ☐ Penicillin
- ☐ Sulfa
- ☐ Eye drops
- ☐ Novocain
- ☐ Seasonal
- ☐ Codeine
- ☐ Other...

Social History

- ☐ Computer
- ☐ Reading
- ☐ Tobacco Use
- ☐ Drug Abuse
- ☐ Alcohol Abuse
- ☐ Student
- ☐ Music
- ☐ Skiing
- ☐ Golf
- ☐ Fishing
- ☐ Tennis
- ☐ Shoot
- ☐ Scuba
- ☐ Swim
- ☐ Bike
- ☐ Non-smoker
- ☐ No alcohol or drug abuse
- ☐ Other...

Current Medicines	Amount

Family History

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

Lifestyle Questions

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

- ☐ work at a computer? How many hours a day?
- ☐ think you might benefit from thinner lenses?
- ☐ have interest in a "test drive' of the latest contact lenses.
- ☐ spend time outdoors?
- ☐ prefer not to wear your glasses at times?
- ☐ want information on Laser Vision Correction surgery
- ☐ have more than 1 pair of current Rx eyewear?

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not Fountains Eyecare Center, PC. **If your insurance company has not reimbursed our office in full within 60 days, you are responsible for providing payment in full to Fountains Eyecare Center, PC.** *Also, please note that insurance does NOT cover Contact Lens Evaluation and Follow-up.* Dr. Jones requires digital retinal imaging as part of your comprehensive eye exam. The fee is $20 for this test. Vision insurance typically does not cover any advanced screening technology as part of a comprehensive eye exam. Your information is protected by our privacy policy. ***I have received a copy of Fountains Eyecare Center, P.C. "Notice of Privacy Practices".***

Signature_______________________________ Date_____________