Today's Date _____

Patient Information

Last _____
First _____MI _____
Street _____
City _____ State _____
Zip Code _____
Home Phone _____
Work Phone _____
Cell Phone _____
Email Address _____
How do you prefer to be contacted?
(Indicate #1 and #2 Choice):
Home #___Work #___Cell #___Text___Email____
Patient's SSN _____
Employer (or School) _____
Occupation (or Grade) _____
Spouse (or Parent's Name) _____
Spouse (or Parent's Work) _____
Date of Birth _____Age _____
Sex M F
What is the major purpose of this visit?

_____
Any problems with your current contact lenses or glasses?_____

_____

VERY IMPORTANT! NEW PATIENTS ONLY:
Who may we thank for referring you to our office?

Name of friend or relative _____

If not referred, how did you choose our office?
❑ Another Doctor
❑ Insurance List
❑ Saw Sign/Building
❑ Newspaper/Radio/TV
❑ Yellow Pages: Which directory? _____
❑ Web Page: Which Web Site? _____
❑ Other _____

Clear Form

Welcome to our office!

Allison Jones, O.D.
David Jones, O.D.

(605) 582-4400 Brandon
(605) 528-7000 Hartford
www.jonesfamilyeye.com

Lifestyle Questions

Do you……(check box if your answer is yes)

❑..work at a computer?
❑..think you might benefit from thinner, lighter lenses?
❑..have interest in a "test drive" of the latest contact lens designs?
❑..spend time outdoors? How much? __Hrs/week
❑..have prescription sunwear?
❑..prefer not to wear your glasses at times?
❑..want information on Laser Vision Correction surgery?
❑..have more than 1 pair of current Rx eyewear?
❑..have children?
❑..have family members in need of eyecare?

Have you ever experienced, been diagnosed or treated for any of the following?

❑ Cataracts
❑ Crossed eye/Eye turn
❑ Eye Infections
❑ Flash of light
❑ Glaucoma
❑ Headaches
❑ Itchiness
❑ Macular Degeneration
❑ Retinal Detachment
❑ Tearing
❑ Corneal Abrasions
❑ Double Vision
❑ Eye Injury
❑ Floaters/Spots
❑ Grittiness
❑ Iritis/Uveitis
❑ Lazy Eye
❑ Occasional dryness
❑ Sunlight Sensitivity
❑ Trouble seeing at night
❑ Other eye disorders_____

Patient Medical History

Name of Family Physician_____
Town_____
Date of Last Physical Check-up_____

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)_____
_____
_____
_____
_____

Allergies to medications? ❑ Yes ❑ No
If so, what medications?_____
_____
_____

Have you had any eye surgeries? ❑ Yes ❑ No
Please list all eye surgeries:_____
_____

Do you use cigarettes/tobacco or other recreational substances? (Circle which if yes.) ❑ Yes ❑ No
Do you use alcohol? ❑ Yes ❑ No

Are you currently being treated or monitored for any of the following health problems?

	Yes	No
Allergies		
Arthritis		
Blood/Lymph		
Bronchitis		
Cancer		
Cholesterol		
Diabetes		
Digestive		
Ears/Nose/Throat		
Endocrine		
Eczema/Rashes		
Fatigue		
Fevers		
Genitourinary		
High Blood Pressure		
Integumentary (Skin)		
Kidney		
Muscle/Bone		
Neurological		
Psychological		
Respiratory		
Sinus		
Throat Infections		
Thyroid		
Unusual weight losses/gains	❑	

Patient Eye History

Date of Last Eye Exam_____
By Whom?_____

Have you ever tried contact lenses? Yes No

Do you currently wear contact lenses? Yes No
What kind?_____
Solutions used_____

Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No

If you wear bifocals, do the lines or head tilting bother you? ❑ Yes ❑ No

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following?
Please check the boxes below if YES.

		Relationship (Mother's or Father's side)
Blindness	❑	
Cataracts	❑	
Corneal Problems	❑	
Diabetes	❑	
Glaucoma	❑	
Heart Disease	❑	
Lazy Eye	❑	
Macular Degeneration	❑	
Retinal Problems	❑	

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not Jones Family Eyecare.

If your insurance company has not reimbursed our office in full within 60 (or 90) days, you are responsible for providing payment in full to Jones Family Eyecare.

Thank you!

Clear Form