Appointment Date: _____

Last Name | First Name

Address | City, ST ZIP

DOB | SSN

Cell Phone | Work Phone | Home Phone

Email Address

☐ Male
☐ Female

Employer/School | Occupation/Grade

Insurance Information

Medical Insurance | Subscriber/Member ID

Subscriber Name | Subscriber SSN | DOB

Vision Insurance | Member ID

Subscriber Name | Subscriber SSN | DOB

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

I acknowledge that I received a copy of Landsaw, O.D., P.A's Notice of Privacy Practices (Effective 9/23/2013)

I certify that I have and will provide, to the best of my knowledge, Landsaw Eyecare the most up to date information regarding my current health status. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to my child or myself during the period of such eye care, the third party payees and/or health practitioners. If applicable, I authorize and request my insurance company to apply directly to the eye doctor or ophthalmic group insurance benefits otherwise payable to me. I authorize the release of any medical or other information necessary to process claims for my child or myself. I also request payment of government benefits either to myself or to the party who accepts assignment. In addition, I authorize payment of medical benefits to the optometric physician or supplier for services provided to my child or myself. I understand that my eye care insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on the behalf of my dependents.

We will start your custom spectacle order immediately. For this reason, cancellations on spectacles are not permitted. All glasses are custom crafted for each patient with their unique prescription. Also, all spectacle lenses are custom cut to fit the frame each patient has selected. Therefore, patients may not switch frames after their lenses have been cut. For all of these reasons, cash refunds are not possible. At the doctors' discretion, patients who are not satisfied with the vision in their new glasses will have their prescription adjusted at no cost, within 60 days of the original purchase date. Cash refunds are not available on progressive lenses. However, any patient who fails to adapt to their new progressive lenses will have their prescription remade one time into a lens of their choice at no additional charge. All additional policies for products and services please review the **Landsaw Eyecare Polices** form posted.

Patient/Guardian Signature | Date

The information in this **confidential** case history form is **critical** to the evaluation of your vision and health.

Primary Care Physician _____ Phone/FAX Number _____ Date of Last Exam _____

Current Medication List: _____

Allergies to Medication?	☐ Yes ☐ No	If so, what meds?		
Do you use cigarettes/tobacco?	☐ Yes ☐ No	If so, how many packs per day?	# of Years?	
Do you use alcohol?	☐ Yes ☐ No	☐ Socially	☐ Daily #	
Do you use illegal drugs?	☐ Yes ☐ No			
Are you pregnant or nursing?	☐ Yes ☐ No			
Have you had any surgeries?	☐ Yes ☐ No	**Please list:**		

Hobbies: _____

Reason for Today's Visit: _____

Eye History

Date of Last Eye Exam: _____

Where? _____

EYEWEAR HISTORY

Have you tried contact lenses?	☐ Yes	☐ No
Do you wear contacts lenses?	☐ Yes	☐ No
Do you sleep in your contacts?	☐ Yes	☐ No
Are your contacts comfortable?	☐ Yes	☐ No
Do you have glasses?	☐ Yes	☐ No
Do you have sunglasses?	☐ Yes	☐ No
Are you planning to have contact lens evaluation & management today?*	☐ **Yes**	☐ **No**

*Additional fees apply, $64 to $375, depending on the complexity

COMPUTER HISTORY

How many hours are you on a computer? _____

Headaches?	☐ Mild	☐ Moderate	☐ Severe
Burning Eyes?	☐ Mild	☐ Moderate	☐ Severe
Dry, tired or sore eyes?	☐ Mild	☐ Moderate	☐ Severe
Squinting at computer?	☐ Mild	☐ Moderate	☐ Severe
Double vision?	☐ Mild	☐ Moderate	☐ Severe
Distance is blurry after computer use?	☐ Mild	☐ Moderate	☐ Severe
Overall body fatigue or tiredness?	☐ Mild	☐ Moderate	☐ Severe
Neck, shoulder or back pain?	☐ Mild	☐ Moderate	☐ Severe
Driving/Night vision is worse after computer use?	☐ Mild	☐ Moderate	☐ Severe

Medical History

Medical History	*Self*	*Family Member(s)*
OCCULAR HISTORY		
Macular Degeneration	☐ **Yes** ☐ **No**	☐ _____
Retinal Detachment	☐ Yes ☐ No	☐ _____
Glaucoma	☐ **Yes** ☐ **No**	☐ _____
Cataracts	☐ Yes ☐ No	☐ _____
Medical History		
Allergies	☐ Yes ☐ No	☐ _____
Blood/Lymph Nodes	☐ Yes ☐ No	☐ _____
Cancer	☐ Yes ☐ No	☐ _____
Cholesterol	☐ **Yes** ☐ **No**	☐ _____
Chronic Bronchitis	☐ Yes ☐ No	☐ _____
Diabetes	☐ **Yes** ☐ **No**	☐ _____
Digestive	☐ Yes ☐ No	☐ _____
Ear/Nose/Throat	☐ Yes ☐ No	☐ _____
Endocrine	☐ Yes ☐ No	☐ _____
Fatigue	☐ Yes ☐ No	☐ _____
Fever	☐ Yes ☐ No	☐ _____
Genitourinary	☐ Yes ☐ No	☐ _____
High Blood Pressure	☐ **Yes** ☐ **No**	☐ _____
Kidney	☐ Yes ☐ No	☐ _____
Muscle/Bone	☐ Yes ☐ No	☐ _____
Neurological	☐ Yes ☐ No	☐ _____
Psoriasis/Eczema/Rashes	☐ Yes ☐ No	☐ _____
Psychological	☐ Yes ☐ No	☐ _____
Respiratory	☐ Yes ☐ No	☐ _____
Rheumatoid	☐ **Yes** ☐ **No**	☐ _____
Arthritis/Lupus	☐ **Yes** ☐ **No**	☐ _____
Sinus	☐ Yes ☐ No	☐ _____
Throat Infections	☐ Yes ☐ No	☐ _____
Thyroid	☐ **Yes** ☐ **No**	☐ _____
Unusual Weight Loss/Gain	☐ Yes ☐ No	☐ _____