COPPER VIEW
EYE CARE

PATIENT INFORMATION

Patient Name _____
Patient Date of Birth / / Sex: M/F Phone # _____ Home/Cell/Work
Address _____
City _____ State _____ Zip _____
Email _____ May we text reminders? YES/NO
How did you hear about us? _____

INSURANCE INFORMATION

Insurance Name _____ Name of insured _____
Insured DOB / / Insured's Employer _____
Primary Medical Insurance _____

What is the primary purpose of this visit?

_____

Do you wear: □ **Glasses** □ **Soft Contacts** □ **RGPs**

How often do you replace your contacts?

□ Daily □ Bi-weekly □ Monthly

Date of last eye exam (approximate)

_____

Have you ever been diagnosed with the following?

□ Cataracts □ Glaucoma □ Lazy Eye/Amblyopia
□ Macular Degeneration □ Dry Eye □ Eye Injury
□ Retinal Detachment □ Keratoconus

CURRENT MEDICATIONS

LIST:_____
Allergic to any medications? Yes/No
If yes, please list:

_____
Do you use cigarettes/tobacco? Yes/No
Do you drink alcohol? Yes/No
Are you pregnant or nursing? Yes/No

PATIENT HEALTH HISTORY

Have you been diagnosed or treated for any of the following: *(Please Circle)*

□ **Eye** (Cataracts, Macular Degeneration, Glaucoma)
□ **Cardiovascular** (Blood Pressure, Cholesterol)
□ **Endocrine** (Diabetes, Thyroid)
□ **Genitourinary** (Genitals, Kidney, Bladder)
□ **Ears/Nose/Throat** (Sinus, Cough, Dry mouth)
□ **Blood** (HIV, Sickle Cell, Anemia)
□ **Gastrointestinal** (Ulcers, Reflux, Crohn's)
□ **Skin** (Rash, Eczema, Cancer)
□ **Muscle/Bone** (Arthritis, Fibromyalgia)
□ **Neurological** (Seizures, Migraines)
□ **Psychiatric** (Depression, Anxiety, ADHD)
□ **Lungs** (Asthma, Bronchitis, COPD)

Other medical conditions: _____

FAMILY EYE HISTORY & RELATIONSHIP

□ **Macular Degeneration** _____
□ **Glaucoma** _____
□ **Other** _____

☐ I would like to have the Clarus Retinal Photo performed for a $39 co-pay. *(Doctor Recommended)*

☐ I would like to have my eyes dilated today. (Side effects include light sensitivity and blurred vision)

☐ I refuse both the Clarus Retinal Photo and dilation against my doctor's recommendation.

As a courtesy, Copper View Eye Care may file claims to my insurance carrier. If I do not have insurance, it is required that I pay in full at the time of service. I understand it is my responsibility to pay any co-pay, deductible or other balance not paid by my insurance. I understand co-pays and deductibles are due at the time of service. In the event of non-payment, I am responsible for all collection costs, collection agency fees (of up to 50%) with or without suit, and attorney fees.

Patient, parent or responsible party: _____ Date: _____