WELCOME TO OUR OFFICE

Welcome to Hook Eye Care. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and we appreciate the confidence you placed in us. Please take a moment to complete the following information. If you have any questions, please do not hesitate to ask.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

_____ _____ _____
First Name MI Last Name

_____
Street Address City State Zip

_____ _____ _____ _____
Social Security Number Date of Birth Home Phone Work Phone

Status (check all that apply) ☐ Single ☐ Married ☐ Other ☐ Full Time Student ☐ Part Time Student

_____ _____ _____
Email address Spouse or Parent(s) Name Person Responsible for Account

_____ _____ _____
Employer Occupation Number of years

_____ _____ _____
School Name Teacher' Name and Grade Cell Phone

What is the main reason for today's exam?_____ When was your last exam?_____

How were you referred to our office? ☐ Phone Book ☐ School ☐ Advertisement ☐ Insurance Listing ☐ Drive by

☐ Patient (please name)_____☐ Doctor (please name)_____☐ Other_____

Primary Insurance Information

_____
Name and Address of Primary Insurance Company

_____ ___ _____ _____
Insured's First Name MI Last Name Insured's Date of Birth

Patient Relationship to Insured

_____ _____ ☐ Self ☐ Spouse ☐ Child ☐ Other
Insured's Identification Number Group Number

Secondary Insurance Information

_____
Name and Address of Primary Insurance Company

_____ ___ _____ _____
Insured's First Name MI Last Name Insured's Date of Birth

Patient Relationship to Insured

_____ _____ ☐ Self ☐ Spouse ☐ Child ☐ Other
Insured's Identification Number Group Number

Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to Hook Eye Care, Todd W. Hook, O.D., P.A. I understand that my primary insurance will be billed. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

_____ _____
Signature Date

Name:

PATIENT HISTORY AND INFORMATION

VISUAL HISTORY

Do you use a computer? ☐ Yes ☐ No How many hours/day?_____ Distance from computer?_____

Do you drive? ☐ Yes ☐ No Do you have visual difficulty when driving? ☐ Yes ☐ No

Do you have glare problems? ☐ Yes ☐ No Do you have visual problems at night? ☐ Yes ☐ No

SPECTACLE LENS HISTORY

Do you currently wear glasses? ☐ Yes ☐ No Type of glasses: ☐ Full time ☐ Part time ☐ Distance ☐ Close

Check all glasses owned: ☐ Single Vision ☐ Bifocals ☐ Progressive ☐ Trifocals ☐ Back-up ☐ Safety ☐ Sports

Have you had trouble in the past with glasses? ☐ Yes ☐ No (specify)_____

Do you wear sunglasses? ☐ Yes ☐ No Are your sunglasses your current prescription? ☐ Yes ☐ No

CONTACT LENS HISTORY

Have you ever tried to wear contact lenses? ☐ Yes ☐ No Do you currently wear contact lenses? ☐ Yes ☐ No Since_____

If not a contact lens wearer, are you interested in trying contact lenses at this time? ☐ Yes ☐ No

List any reasons for stopping _____ Today's wearing time _____

Brand of contact lens worn (or type)_____ Right eye power:_____ Left eye power:_____

How many hours/day wear time? _____ How many days/week? _____ How often are the lenses replaced? _____

Please rate the following on a scale of 1-10, with 1 being POOR to 10 being EXCELLENT

Lens Comfort: Right_____ Left_____ Distance Vision: Right_____Left_____ Near Vision: Right_____Left_____

What solutions do you use? Cleaner_____ Disinfectant_____ Enzyme _____

Do you use any artificial tear drops or rewetting solution? ☐ Yes ☐ No List Brand_____

SOCIAL HISTORY

Do you use nutritional supplements (vitamins, etc.)? ☐ Yes ☐ No Name of Pharmacy _____

Do you engage in regular exercise? ☐ Yes ☐ No

Do you drink alcohol and if yes, how much/often? ☐ No ☐ Occasional ☐ 1 per day ☐ 2-3/ day ☐ 4+/day

Do you smoke and if yes, how much/often? ☐ No ☐ Occasional ☐ ½ pack/day ☐ 1 pack/day ☐ 1+ pack/day

Hobbies/Interests: _____

SPECIAL EYEWEAR NEEDS

☐ Computer (special prescriptions, anti-glare coatings and tints)

☐ Occupational (mechanics, plumbers, pilots)

☐ Safety Glasses (gardening woodworking, welding)

☐ Sports/Hobbies (racquet sports, motorcycle, etc)

Name:

MEDICAL HISTORY QUESTIONAIRE

EYE HISTORY

☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Blurred Distance Vision
☐ Yes	☐ No	Glare/Light Sensitivity	☐ Yes	☐ No	Blurred Near Vision
☐ Yes	☐ No	Tired Eyes	☐ Yes	☐ No	Distorted Vision
☐ Yes	☐ No	Lazy Eye	☐ Yes	☐ No	Double Vision
☐ Yes	☐ No	Burning/Itching	☐ Yes	☐ No	Floaters or Spots
☐ Yes	☐ No	Dryness	☐ Yes	☐ No	Fluctuating Vision
☐ Yes	☐ No	Excess Tearing /Watering	☐ Yes	☐ No	Loss of Vision
☐ Yes	☐ No	Eye Pain or Soreness	☐ Yes	☐ No	Loss of Side Vision
☐ Yes	☐ No	Foreign Body Sensation	☐ Yes	☐ No	Drooping Eyelid
☐ Yes	☐ No	Infection of Eye or Lid	☐ Yes	☐ No	Redness
☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Sandy or Gritty Feeling
☐ Yes	☐ No	Mucous Discharge	☐ Yes	☐ No	Crossed Eyes

GENERAL HEALTH CONDITION (please list specifics and length of time affected by condition)

☐ Yes	☐ No	Fever _____	☐ Yes	☐ No	Kidney Disease _____
☐ Yes	☐ No	Heart Ds / Stroke _____	☐ Yes	☐ No	Arthritis / Inflammatory_____
☐ Yes	☐ No	Liver / Hepatitis _____	☐ Yes	☐ No	Skin Disease _____
☐ Yes	☐ No	Ears, Nose, Throat_____	☐ Yes	☐ No	Neurological Ds _____
☐ Yes	☐ No	Hypertension _____	☐ Yes	☐ No	Anxiety, Depression, etc _____
☐ Yes	☐ No	Asthma, Respiratory Ds _____	☐ Yes	☐ No	Diabetes_____
☐ Yes	☐ No	Gastrointestinal _____	☐ Yes	☐ No	Blood Disorder _____
☐ Yes	☐ No	Psychiatric Disorder _____	☐ Yes	☐ No	Thyroid Ds _____

Are you currently pregnant or nursing? ☐ Yes ☐ No When was your last health exam? _____

Past Illnesses or Injuries: _____

Past Surgeries: _____

Medicines that cause reactions or sensitivities: _____

Specific Allergies: _____

List current medications and conditions for which they are taken:

_____-_____ _____-_____ _____-_____

_____-_____ _____-_____ _____-_____

_____-_____ _____-_____ _____-_____

FAMILY HISTORY (please list relationship to patient)

☐ Yes	☐ No	Lazy Eye	☐ Yes	☐ No	Blindness	☐ Yes	☐ No	Cataracts
☐ Yes	☐ No	Color Blindness	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Macular Degeneration
☐ Yes	☐ No	Retinal Detachment	☐ Yes	☐ No	Other Eye Disorder_____			
☐ Yes	☐ No	Cancer	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Heart Disease
☐ Yes	☐ No	Hypertension	☐ Yes	☐ No	Stroke	☐ Yes	☐ No	Thyroid Disease
☐ Yes	☐ No	Arthritis	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Lupus