



CORNELL EYECARE

DR. CHAD W. LAWSON

NEW Patient Information (All information will be Confidential)

Patient _____ Today's Date _____ Date of Birth _____ M / F

Address _____

City/State/Zip _____

Phone: Home _____ Work _____ Cell # _____

Marital Status: _____ E-mail address _____

Parent/Guardian (if patient is under age 18) _____

Reason for today's visit: _____ GLASSES CONTACT LENSES

Whom may we thank for referring you to our office?

- Family Member _____ Friend _____
- Other healthcare professional _____
- Radio _____ Paper _____ Yellow pages _____ Office Web site _____
- Office sign/drive by _____ Insurance listing _____

Insurance Information

S. S. # _____

Employer Name _____

Vision Insurance Co. _____

Medical Insurance Co. _____

Name of *primary* insured _____

Name of insured _____

ID/Policy# _____

ID/Policy# _____

Group# _____

Group# _____

DO YOU HAVE ADDITIONAL INSURANCE WE SHOULD BILL? yes no

If so, please complete the following:

Name of insured _____

Relationship to patient _____

Group # or Employer Name _____

Insured S. S. # _____

Visual Information

Date of last vision exam _____

Please circle all that you are experiencing with your current correction:

- | | | |
|--|--|---|
| <input type="checkbox"/> Blur far away | <input type="checkbox"/> Eyes itch | <input type="checkbox"/> Discharge from eyes |
| <input type="checkbox"/> Blur up close | <input type="checkbox"/> Eyes water easily | <input type="checkbox"/> Light sensitivity |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Motion sickness reading in car |
| <input type="checkbox"/> Squinting | <input type="checkbox"/> Sleepy w/reading | <input type="checkbox"/> Nausea or stomach problems |
| <input type="checkbox"/> Night vision problems | <input type="checkbox"/> Frequent loss of place when reading | <input type="checkbox"/> Pain in or around eyes |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Reading held at 10" or less | <input type="checkbox"/> Eye strain/tired eyes |
| <input type="checkbox"/> Eyes burn | | <input type="checkbox"/> Floaters or spots |

Have you had any eye injury, infection or surgery?

yes no Explain _____

Contact Lens Wearers

If you currently wear contacts, what brand and type are they? soft gas perm Brand _____

Please initial that you have read and understand the contact lens fitting fees listed in our Contact Lens Information Sheet provided on this clipboard. _____

Health Information

Please list any medications you are taking and their purpose:

Have you had any significant changes in your health or any major health problems? yes no

Explain _____

Do you or does anyone in your family have a history of:

			Self	Family		Self	Family
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	Cataract	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Eye Disease	<input type="checkbox"/>	<input type="checkbox"/>	Strabismus (crossed eyes)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Amblyopia (lazy eye)	<input type="checkbox"/>	<input type="checkbox"/>			

Do you use any of the following on a regular basis: ____Tobacco ____Alcohol ____Other Substances

Are you allergic to any medications? yes no

Please list _____

Lifestyle Factors! Your answers will assist us in selecting the best eyewear for you!

Occupation _____ Spouses' Occupation _____

Are you required to wear safety glasses at work? yes no

Do you work at a computer or video display terminal? yes no

Are you tired of wearing glasses and interested in contacts? yes no

If you currently wear contacts, what brand and type are they? soft gas perm Brand _____

Are you interested in getting updated glasses? yes no

Do you have a back-up pair of glasses available? yes no

Do you have prescription sunglasses? yes no

Are your sunglasses polarized (whether prescription or not)? yes no

Do you have an east-west commute? yes no

Does road glare bother you? yes no

What hobbies, social activities or sports do you participate in?

FRAME POLICY

Please initial that you have read and understand the Frame Policy information Sheet provided on this clipboard.

PAYMENT POLICY

Please initial that you have read and understand the Cornell Eyecare Group Payment Policy provided on this clipboard.

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered.

X _____