Robert M. Easton Jr OD PA @ www.EastonEyeCare.com
1560 East Oakland Park Blvd. Oakland Park, FL 33334-4425 (954)-564-2025

Welcome to our office. We are glad that you have chosen us to provide you comprehensive eye care, precision contact lens design and fashion eyewear. Please complete this form and circle items and bring it with you to your eye exam or, to expedite insurance coverage approvals, return it prior to the eye exam by **Fax – to 954-564-3869. In addition, please fax both sides of your insurance card so we can input this information into our system prior to your visit to save time for you.**

Payment Information:
Driver's License # (if paying by check):

_____ _____

Payment Preference: Please circle
Cash Check Visa MC Amex
Discover Care Credit HSA

Patient Information as of Today's Date ___ /_ __ / 20___

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Miss

Name:_____

Address: _____

City: _____ State: _____ Zip:_____

Email: _____

Work Phone: _____

Cell Phone: _____

Occupation: _____

Date of Birth: _____/_____/_____ Height_____ Weight_____

Social Security #: _____-_____-_____

CONTACT LENS PATIENTS
Please circle

Have you ever worn contact lenses in the past?	N Y
Do you currently wear contact lenses?	N Y
Are you interested in lenses, which enhance or change your eye color?	N Y
Do you want to sleep or nap in your lenses?	N Y
Do your eyes become dry, itchy, or irritated while wearing contacts?	N Y
Do your contacts become less comfortable as the day progresses?	N Y
Are you interested in learning about the latest advances in contact lenses?	N Y

Family Physician: _____

Address: _____

Referred by: _____

Have you ever been to this office before? No Yes

Approx. date of last eye examination: _____

By Doctor: _____
If the patient is a minor:
Grade: _____ School: _____

Responsible Person for Payment: _____

Type of contact lenses worn and solutions used:
Please circle CL type you wear

Soft Extended-Wear Dailey-Wear Gas Permeable
1 Day Multifocal Bifocal Toric (Astigmatism) Disposable
Keratoconus Specialty Lens

Age of present contact lenses: _____

Date of last contact lens exam: _____

How many hours per day do you wear your contacts? ____

What contact lens cleaning/disinfection solution are you using?

_____

Vision or Major Medical Insurance Information:

Plan Name: _____

Insured's Name: _____

Member ID #: _____

Group #: _____

Patient's relationship to insured: _____

We will file insurance for any plan under which we are providers. If you have a question about which plans we are providers, please ask our receptionist. ***Payment is expected at time of treatment.***

EYEGLASS PATIENTS:
Please circle

I wear my glasses: Full Time Distance/Driving

Near/Reading Computer Sports Outdoors/Sun

Age of present glasses: _____ Last exam date: _____
from Dr. _____
Occupation: _____
Hobbies: _____
Would you be interested in maintenance-free 1 Day Contact Lenses for part-time wear? No Yes
Do you spend time on a computer? No Yes
If yes, how many hours per day? _____
How far is your computer screen to your eyes? _____"

Have you been treated or diagnosed for any of the following conditions?
Please circle conditions you have

Diabetes Glaucoma High Blood Pressure Cataracts Thyroid Problems Heart Disease Allergies High Cholesterol

High Triglycerides Eye Disease Eye Infections Double vision Eye or Head Injuries Amblyopia or Lazy Eye Kidney Problems

Strabismus or Eye Turn Drug Sensitivities Seizures Skin Conditions Respiratory problems Cancer Migraines

Macular Degeneration Blurry Distance Vision Blurry Intermediate or Near Vision Keratoconus

Other _____ Trauma or car accidents _____

Do you have any current health problems? No Yes
If yes, please list: _____
Please list any medications you are currently taking (include hormones, vitamins, birth control pills or any eye drops): _____
Are you allergic to any medications, food, or pollen? No Yes
If yes, please list: _____
If you have had an eye infection, eye injury, or eye surgery, please describe: _____
Have you ever had any surgery elsewhere? If so, please describe: _____
Have you ever experienced any head or eye trauma or car accident(s)? If so, please describe: _____
_____
If you are currently being treated for any medical conditions, please describe: _____
Last general health exam date: _____ Have you ever received vision training or eye exercise? No Yes

Please circle any symptoms you have:
Blurred Vision Crusty Discharge Tearing
Frequent Headaches Double Vision Dizziness
Flashing Lights Eye Pain Itching Burning Twitching
Light sensitivity Aching Floaters

Family History - Has anyone in your family been treated or diagnosed for any of the following conditions? If so, please list their relationship to you: Elevated Cholesterol_____
Diabetes _____ Glaucoma _____
High Blood Pressure _____ Cataracts _____
Thyroid Problems_____ Blindness_____
Heart Disease_____ Cancer_____
Keratoconus_____ Macular Degeneration_____
Strabismus_____ Kidney Problems_____
Stroke_____ Other_____

Charges for eye medical services, eyeglasses and/or contact lenses are due and payable at the time that services and/or eyeglasses or contact lenses are dispensed. Our office will be happy to assist you in filing your insurance form. Collection costs and/or reasonable attorney fees will be due in the event that any collection process becomes necessary.

I request that payment of authorized Medicare benefits or other insurance be made either to me or on my behalf to Dr. Easton for any services furnished to me by that doctor. I authorize any holder of medical information about me to release to the health care financing Administration and its agents, any information needed to determine these benefits or the benefits payable for related services

Lifetime Patient Signature: _____
Date: _____/_____/_____