Front Range EYE Associates
Excellence You Can See

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Name: _____ Date: _____/_____/_____

☐ Change in Address

Street Address: _____City: _____State: ___ ZIP: _____

☐ Change in Phone Number

Home Phone (_____)_____ Cell Phone (_____)_____ Work Phone: (_____) _____

☐ Change in Vision Insurance *(Please present copy of card or we will be unable to bill on your behalf.)*

☐ VSP ☐ EyeMed ☐ Vision Insurance is through Medical Insurance ☐ Other _____

☐ Change in Medical Insurance *(Please present copy of card or we will be unable to bill on your behalf.)*

☐ United Health Care ☐ Medicare ☐ Kaiser ☐ Rocky Mountain Health
☐ Cigna ☐ TriCare ☐ Aetna ☐ Other _____
☐ BC/BS/Anthem ☐ Sloans Lake ☐ Great West

☐ Change in Eye History

Do you experience any of the following?

❑ Itchy Eyes ❑ Tired Eyes ❑ Mucous Discharge ❑ Blurred Vision
❑ Dry Eyes ❑ Eye Strain ❑ Glare/Excess Light Sensitivity ❑ Distorted Vision/ Halos
❑ Sandy/Gritty Eyes ❑ Headaches
❑ Burning ❑ Red Eyes ❑ Floaters in Vision ❑ Double Vision
❑ Eye Pain ❑ Excess Tearing/ Watering ❑ Loss of Vision

Are you interested in LASER refractive surgery? ☐ Yes ☐ No

Do you work on a computer? ☐ Yes ☐ No If yes, how many hours per day? ____Distance between eyes & monitor ____

☐ Change in Medical History - Please indicate any **NEW** problems since your last exam.

Ear/Nose/Throat	☐	Musculoskeletal	☐
Cardiovascular	☐	Neurological	☐
Respiratory	☐	Lymphatic/ Hematologic	☐
Gastrointestinal	☐	Endocrine	☐
Genitourinary	☐	Psychiatric	☐
Integumentary (Skin)	☐		

Please explain any YES answers: _____

_____

☐ Hobbies

☐ Computer Use ☐ Running ☐ Basketball ☐ Hunting
☐ Skiing/ Boarding ☐ Fishing ☐ Volleyball ☐ Motorcycling
☐ Racquet Sports ☐ Woodwork ☐ Hiking ☐ Golf

Thank you for choosing our office for all your eye health and vision needs!

Drs' Initials_____