Dr. Mary Anne C. Murphy   Dr. Shira L. Pipkin   Dr. Marisa A. Perez-Wilson

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E: info@FR-EA.com I: www. FR-EA.com

Date: _______/_________/_________

First Name: ______________________________ MI:____ Last Name: _________________________________

Address: ____ SSN: _________________________

City: ____ State: ________ ZIP: ___________

Birth Date: _____/_____/_______ ☐ Male ☐ Female Home Phone: (_____) _______________

Email (for appointment reminders): _______________________________ Cell Phone: (_____) ______________

Preferred contact method: ☐ Home Phone ☐ Cell Phone ☐ E-mail **Preferred language:** _________________

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Other_______________ Spouse's Name: __________________

Employer: ____ Work Phone: (_____) ______________

Occupation: ______________________________________ ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Not Employed

Who may we thank for referring you?: ____

Please list any other family members seen at our office: ____

Parent's Names (if patient is a minor): ____

Insured Subscriber's Name: _________________ Insured's SSN: _______________ Birth Date: _____/_____/_____

Address (if different then patient): ____________________________________ Phone :(_____) ______________

Insured Subscriber's Employer: ____

Vision/ Eye Insurance Information *(Please present copy of card or we will be unable to bill on your behalf.)*

☐ VSP ☐ EyeMed ☐ Superior ☐ Comp Benefits ☐ Other _________ ☐ Vision Benefits via Medical Insurance

Medical Insurance Information *(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/Cofinity	☐ Great West	

Lifestyle Questions: Do you enjoy….

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

ACKNOWLEDGEMENT OF RECEIPT/ SIGNATURE AUTHORIZATION

I acknowledge that I have received a copy of the HIPAA Notice of Privacy Practices and I understand how my personal information may be used. I request that insurance benefits be made on my behalf to Front Range Eye Assoc. for any services furnished to me by Front Range Eye Assoc. I understand that I must pay for any services not completely covered by insurance and/or for services for which I am determined to be ineligible.

Signature of Patient (or Responsible Party) ____________________________________ Date _____/_____/______

**** PLEASE COMPLETE PAGE TWO ****

MEDICAL HISTORY QUESTIONNAIRE

Vision History

What is the PRIMARY reason for your visit today?: ______________________________

Name of Primary Care Medical Doctor: ______________________ Dr.'s Phone: (_____) ____________

When was your last eye exam?: ______________________________ With whom?: ____________

Do you wear glasses? ☐ Y ☐ N

Do you wear contact lenses? ☐ Y ☐ N Type of contact lenses: ☐ Rigid ☐ Soft

How often do you replace your lenses? ____________ How often do you sleep in your lenses?: ____________

Have you had any eye surgery? ☐ Y ☐ N If yes, what type?: ______________ When?: ____________

Are you interested in finding out if you are a candidate for LASER refractive surgery (LASIK, PRK)? ☐ Yes ☐ No

Are you *currently* experiencing any of the following?

- ❑ Itchy Eyes
- ❑ Dry Eyes
- ❑ Eye Pain
- ❑ Tired Eyes
- ❑ Headaches
- ❑ Glare/Excess Light Sensitivity
- ❑ Floaters in Vision
- ❑ Loss of Vision
- ❑ Double Vision
- ❑ Eye Allergies

Medical History

Please check any major illnesses:

- ❑ Glaucoma
- ❑ Diabetes
- ❑ High Blood Pressure
- ❑ Thyroid Disorder
- ❑ Arthritis
- ❑ Heart Attack
- ❑ Stroke
- ❑ Blood Clots
- ❑ High Cholesterol
- ❑ Migraines
- ❑ Cancer, type: ____________
- ❑ Other: ____________

Other medical history: ______________________________

Are you currently pregnant or nursing? ☐ Yes ☐ No

Please list <u>any</u> eye drops you are currently using: ______________________________

Please list <u>any</u> prescription or nonprescription medications you are taking, including vitamins & herbal supplements:

____

____

Do you have any drug allergies? ☐ Yes ☐ None known. If yes, list: ______________________________

Family History

Has any member of your family had these diseases? **(Mother, Father, Grandparent, Sibling)**

Disease Condition	Y	N	?	Relationship		Y	N	?	Relationship
Blindness	☐	☐	☐	____________	Diabetes	☐	☐	☐	____________
Crossed Eyes	☐	☐	☐	____________	Heart Disease	☐	☐	☐	____________
Glaucoma	☐	☐	☐	____________	High Blood Pressure	☐	☐	☐	____________
Macular Degeneration	☐	☐	☐	____________	Kidney Disease	☐	☐	☐	____________
Retinal Detach/Disease	☐	☐	☐	____________	Lupus	☐	☐	☐	____________
Rheumatoid Arthritis	☐	☐	☐	____________	Thyroid Disease	☐	☐	☐	____________
Prostate/ Breast Cancer	☐	☐	☐	____________	Other ____________	☐	☐	☐	____________

Social History

Does your vision limit any activities of daily living (driving, computer use, reading, sports, work, etc.)? ☐ Yes ☐ No
If Yes, what?: ______________________________

Do you smoke or use any tobacco products? ☐ Yes ☐ No If YES, how much?: ________ For how many years?: _______

Thank you for choosing Front Range Eye Associates for all your eye and vision needs!