

CONFIDENTIAL

MATTINGLY CENTER FOR SIGHT
1410 Union Street
Lafayette, IN 47904
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Thank you! for choosing Mattingly Center for Sight. We look forward to meeting and serving you. For your added convenience, please bring the following items with you on your first visit:

- ❖ this form, completely filled out (**please note** “patient” and “responsible party” sections below),
- ❖ your insurance card(s), your eye glasses and any medications you are currently taking.

Note: Your pupils may be dilated, and you therefore may desire a driver to assist you.

PATIENT INFORMATION

First Name _____ Middle Initial _____ Last Name _____
 Parent or Guardian (if minor) _____
 Address _____ City _____ State _____ Zip _____
 Home Phone (____) _____ - _____ Work Phone (____) _____ - _____ Marital Status _____
 Social Security # _____ - _____ - _____ DOB ____/____/____ Age _____ Sex (circle): M or F
 Driver’s License # _____ State _____ Email address _____
 Employer Name and Address _____
 Referral source _____ Medical Doctor _____
 Optometrist _____

RESPONSIBLE PARTY INFORMATION (if different than above)

First Name _____ Middle Initial _____ Last Name _____
 Address _____ City _____ State _____ Zip _____
 Home Phone (____) _____ - _____ Work Phone (____) _____ - _____ DOB ____/____/____
 Driver’s License # _____ State _____ Social Security # _____ - _____ - _____
 Employer Name and Address _____

INSURANCE

Primary Insurance _____ Insured’s Name _____ DOB ____/____/____
 Insured’s Employer’s Name and Address _____
 Policy # _____ Group # _____

Secondary Insurance _____ Insured’s Name _____ DOB ____/____/____
 Insured’s Employer’s Name and Address _____
 Policy # _____ Group # _____

Tertiary Insurance _____ Insured’s Name _____ DOB ____/____/____
 Insured’s Employer’s Name and Address _____
 Policy # _____ Group # _____

Medicare (if applicable, circle your supplement): A {retirement} or B {private purchase}

SIGNATURE

By signing below, I accept financial responsibility for all charges not covered by my insurance. I authorize the release of all information acquired in the course of my examination and/or treatment to my insurance company and the physicians involved in my healthcare. I authorize my insurance company to pay benefits on my behalf directly to Mattingly Center for Sight and/or Eyewear by Design.

Signature _____ Printed Name _____ Date ____/____/____

PATIENT LIFESTYLE QUESTIONNAIRE

EYEWEAR

- 1.) Do your glasses sometimes irritate your face? Yes No
- 2.) If you could, would you prefer not to wear glasses? Yes No
- 3.) Are you satisfied with the way your glasses look and feel? Yes No
- 4.) Are you satisfied with the vision and comfort your glasses provide? Yes No
- 5.) If your glasses were lost or destroyed, could you function well at work, at home, and with your hobbies? Yes No
- 6.) Do you wear sunglasses? Yes No
- 7.) If you wear bifocals, are you bothered by the lines or do you sometimes tilt your head to see? Yes No

CONTACTS

- 1.) How often do you wear contact lenses? _____
- 2.) What cleaning solutions do you use? _____
- 3.) Do you experience dry or itchy eyes or dry contacts? Yes No

OCCUPATION

- 1.) What is your occupation? _____
- 2.) Do you work at a computer? Yes No
- 3.) Do you work outdoors? Yes No
- 4.) Do you work in a hazardous environment, such as manufacturing? Yes No

LIFESTYLE

- 1.) What are your hobbies? _____
- 2.) What sports activities do you enjoy? _____
- 3.) How many hours a day do you spend driving? _____
- 4.) Do you spend time with low lighting? Yes No
- 5.) Do you drive frequently at dawn, dusk, or night? _____ Yes No
- 6.) Do you drive frequently with the sun in your eyes? Yes No

COMMENTS

Anything else you would like to share with us? _____

Name			Date		
Do you have?	Yes?	No?	Do you have?	Yes?	No?
Decreased vision			Floaters in vision		
Eye muscle disorder			Flashing lights		
Poor side vision			Eye injury		
Poor night vision			Migraines		
Poor color vision			Corneal disease		
Poor depth perception			Glaucoma		
Light sensitivity			Droopy eyelid		
Haloed around lights			Cataract		
Glare			Previous eye surgery		
Red eye			Skin disease, rash		
Eye prominence (bulging out)			Diabetes		
Eye irritation			Thyroid disease		
Eye dryness			High blood pressure		
Scratchiness, gritty feeling			Heart disease		
Eye itching			Asthma		
Lazy (amblyopic) eye			Emphysema, lung disease		
Mattering of eyelids			Neurological disease		
Tearing of eye(s)			Stroke		
Double vision			Gastrointestinal disease		
Excessive blinking			Arthritis		
Allergies to medicines			Urinary, bladder disease		
Allergies to eye drops			Ear, nose, sinus disease		
Do you smoke now?			Emotional disorders		
Have you smoked over one year?			Blood disorder, bleeding tendency		
Do you have over 4 drinks per day?			Does your family have cataracts?		
Are you concerned that your job is adversely affecting eyes?			Does your family have glaucoma?		
Is there a family history of diabetes?			Is there family history of high blood pressure?		

Please list below major surgeries in past 5 years:

Are there other matters that are of concern? Please explain.

**MATTINGLY CENTER FOR SIGHT
CONSENT TO USE PROTECTED HEALTH INFORMATION**

Our Notice of Privacy Practices describes how we may use and disclose protected health information about you. You have the right to review the notice prior to signing this consent. Our privacy policy may be subject to change. If the notice does change, you may obtain a copy by asking at the front desk.

You have the right to request restrictions on how we use your protected health information for payment, treatment and health care operations. We are not required to agree with your requests for restriction. If we agree to your request, we are bound by our agreement.

You also have the right to revoke this consent, in writing. However, this will not affect any releases we have made before you made the request.

By signing this consent, you are allowing The Mattingly Center for Sight to use your protected health information to carry out treatment, payment and health care operations.

Name of Patient

Signature of Patient or Personal Representative

Date