CONFIDENTIAL

MATTINGLY CENTER FOR SIGHT
1410 Union Street
Lafayette, IN 47904
Phone: (765) 423 – 2977
Fax: (765) 423 – 1149

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. Should I fail to pay any fees not covered by insurance, I agree to be responsible for all costs of collection, including attorney's fees. 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 ____/____/_____

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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		
Haloes 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:

____

____

____

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PATIENT LIFESTYLE QUESTIONAIRE

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? ____
____
____
____

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