Red Eye Eyewear
2158 N. Damen Ave.
Chicago, IL 60647
Phone (773) 782-1660
Fax (773) 782-1501

Today's Date:______________

Name:(First) ______________________________________(MI)_____ (Last)_________________________________

Street Address_______________________________________ City _______________ State_____ Zip__________

Cell # ____________________ Work# ____________________ Home#_____________________

E-mail Address: ____________________________________

Gender: M___ F___ Date of Birth ________________ Social Security #________________________

Employer _________________________ Occupation _______________________ Hobbies__________________

Whom may we thank for referring you to our office? ____

Vision Insurance Name _______________________________ Insured ID# ________________________________

☐ **PLEASE CHECK BOX IF RESPONSBILE PARTY INFORMATION IS THE SAME AS PATIENT INFORMATION ABOVE**

Responsible Party _____________________________ Date of Birth ___________ Social Security _________________

Street Address_______________________________________ City _______________ State_____ Zip__________

What is the main reason for your visit today? ____

Please check if you are experiencing any of the following:

☐ Dry Eyes ☐ Red Eyes ☐ Itchy Eyes ☐ Irritated Eyes ☐ Headaches/Migraines

☐ Blur at Distance ☐ Blur at Near ☐ Blur at Computer ☐ Eye Strain ☐ Glare

☐ Floaters ☐ Vision Loss ☐ Other ____

Please check if **you or anyone in your family** has ever experienced the following eye problems:

	You	Family		You	Family
Cataracts	☐	☐	Lazy eye	☐	☐
Cataract surgery	☐	☐	Eye turn	☐	☐
Glaucoma	☐	☐	Eye surgery	☐	☐
Macular Degeneration	☐	☐	Eye trauma	☐	☐
Retinal Detachment	☐	☐	Keratoconus	☐	☐
Diabetic Retinopathy	☐	☐	Other:__________________		

Have **you or anyone in your family** ever been diagnosed with or have had a significant problem with:

	You	Family		You	Family
High blood pressure	☐	☐	Arthritis	☐	☐
Diabetes	☐	☐	Mental health	☐	☐
Heart disease	☐	☐	Smoking	☐	☐
High Cholesterol	☐	☐	Stroke	☐	☐
Currently Pregnant	☐		Asthma	☐	
Cancer	☐	☐			

Type(s) ________________________ Other ____

Almost Done! Over Please →

Contact Lenses

Do you wear contact lenses? Yes / No   Are you interested in being fit for contacts today? Yes / No

If you wear/wore contact lenses: Current brand ______________________Previous brand______________________

How long have you worn contact lenses? Less than 1 year / 2 to 5 years / Longer than 5 years

How often do you replace your contact lenses? Daily / 2 weeks / 1 month / 1 year / Other ______________

How often do you sleep in your lenses? _______________times per week

Which solutions do you use? Aquify / Optifree / Renu / ClearCare / Complete / Generic brand / Any

Please list any allergies (environmental or medication) that you may have:

________________________________ ________________________________ ______________________________

________________________________ ________________________________ ______________________________

________________________________ ________________________________ ______________________________

Please give a complete list of medications that you are currently taking:

Medication	Reason Taken (if known)	Dosage (if known)

I authorize Red Eye Eyewear to bill my insurance when possible. I understand that the amounts quoted are not a guarantee of benefits and that I may be financially responsible for charges not covered by my insurance. I authorize the use of my signature on all insurance submissions. I acknowledge that I was offered an opportunity to review or requested and received a copy of our Notice of Privacy Practice for HIPPA.

Patient/Guardian Signature: ____ Date _____________