Dr. Paul Degenaer, O.D. and Associates

5001 McKinney Ranch Pkwy, Ste A
McKinney, Texas 75070
Tel: 972-547-4200 / Fax: 972-547-4202

730 West Exchange Pkwy, Ste A
Allen, Texas 75013
Tel: 214-383-2321 / Fax: 214-383-2322

General Patient Information

Are you a: ☐ **New Patient** ☐ **Current Patient**

Reason for today's visit: ☐ Vision Decreased ☐ Distance ☐ Near ☐ Computer
☐ Irritation ☐ Redness ☐ Other: ____________________

Section A: Personal Information

________________ Last Name ________________ First Name ______ MI ________________ Preferred Name

____ Street Address City State Zip Code

________________ Home Phone ________________ Business Phone ________________ Cell Phone ________________ Date of Birth

________________________ Parent/Guardian (If Minor) ________________________ Email Address

________________________ Occupation ________________________ Employer

For your annual recall, please indicate contact preference: ☐ **Email** ☐ **Text** ☐ **Postcard**

How did you hear about our office? ____

Referred by: ____

Section B: Insurance Information

☐ I have no insurance at this time.

Vision Plan/Coverage	**Medical Insurance**
Vision Provider:	Medical Provider:
Primary Name:	Primary Name:
Subscriber ID:	Subscriber ID:
Primary Social:	Primary Social:
Primary Date of Birth:	Primary Date of Birth:
Relationship to Primary:	Relationship to Primary:

In the event that your vision/medical insurance provider determines that you are not eligible for visual coverage at the time of service, or makes a determination that you are only eligible for a reduced level of coverage, by signing this statement you hereby agree to be financially responsible for any and all charges incurred by you and not paid by your insurance provider.

In the event you do not have vision/medical insurance coverage, you are responsible for payment in full for services rendered today.

Parent/Guardian Signature: ________________________ **Date:** ________________

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Section C: Medical History

List all medical conditions you are receiving treatment, the term of treatment and any medications you are taking (including vitamins, supplements, and birth control)

Medical Condition:	How long it's being treated:	Current medications:

List all medication to which you are **allergic**: ______________________________

Are you a smoker? ☐ Yes ☐ No ☐ Used to How long did you smoke? ____________ When did you quit? ______________

Check **all medical** conditions that apply to you:

☐ Diabetes ☐ High Blood Pressure ☐ Asthmas ☐ Cancer Type: _________
☐ Headaches ☐ Seasonal Allergies ☐ Heart Disease ☐ Arthritis ☐ Stroke/TIA's
☐ Seizures ☐ Kidney Disease ☐ High Cholesterol ☐ Thyroid Disease
☐ Head Trauma ☐ Lung Disease ☐ Vascular Diseases ☐ Gastro/Intestinal
☐ Past Trauma: ______________________________ ☐ Other: (Please list) ______________________________

Check conditions that are present in other family members:

☐ Cataracts ☐ Glaucoma ☐ Diabetes ☐ High Blood Pressure
☐ Heart Disease ☐ High Cholesterol ☐ Stroke/TIA's ☐ Macular Degeneration
☐ Cancer Type: ________________________ ☐ Other EYE Diseases (Please list): _________________________
☐ Other Inherited Conditions (Please list): ____

Section D: Vision History

Check **all eye** conditions that apply to you:

☐ Eye Surgery Type: _____________________________ ☐ Cataract ☐ Glaucoma ☐ Dry Eye
☐ Lazy Eye ☐ Strabismus (Eye Turn) ☐ Keratoconus ☐ Prosthesis ☐ Retinitis Pigmentosa
☐ Light Flashes ☐ Floaters ☐ Corneal Transplant ☐ Macular Degeneration
☐ Vision Therapy ☐ Past Eye Injury: ___________________________ Other: _____________________________

Contact Lens Information

☐ I would like to know my contact options. ☐ I do not wear contacts. ☐ I am not interested in contacts.

When was the last time you wore contacts? ____________________________ Do you sleep in your contacts? _________________

Are they: ☐ Soft ☐ Toric ☐ Bifocal/Monovision ☐ RGP # of nights you sleep in your contacts: ____

How often do you replace them? ☐ Daily ☐ Weekly ☐ Two weeks ☐ Monthly ☐ Other: ________

Brand of current contacts: ____________________________________ Solution used with contacts: _________________________

Powers of current contacts: Right Eye ________________________________ Left Eye ____________________________________

Are you having problems with your contacts (i.e. dry, uncomfortable, blurry): ____

Have you heard of a contact that you would like to try? _________________________ If so, what brand?_______________________

Why would you like to try this contact? ____