Lunette Boston, PC
Welcome To Our Office

Welcome to Lunette Boston, PC. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please review all completed areas to ensure that the information we have is current and accurate. PLEASE NOTE- IT IS YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE BENEFITS, ELIGIBILITY IS NOT PROOF OR FINAL PAYMENT. A CONTACT LENS EVALUATION OR FITTING IS NOT PART OF A ROUTINE EYE EXAM. If you have any questions, please do not hesitate to ask.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name _____ MI _____ Last Name _____ Preferred Name _____

Street Address _____ City _____ State _____ Zip _____

Social Security Number _____ Date of Birth _____ Home Phone - Include Area Code _____ Day Phone _____

Email Address _____ Guardian _____ Person Responsible for Account _____

Emergency Contact _____ Emergency Phone _____

How were you referred to our office?

☐ Phone Book ☐ School ☐ Advertisement ☐ Patient

☐ Insurance Listing ☐ Drive by ☐ Other ☐ Doctor

Who were you referred by? _____

MEDICAL INSURANCE INFORMATION

Name and Address of Primary Insurance Company _____ City _____ State _____ Zip _____

M ☐ F ☐ Insured's First Name _____ MI _____ Insured's Last Name _____

Insured's Identification Number _____ Group Number _____ Insured's Date of Birth _____

Patient Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status

☐ Single ☐ Married ☐ Other

☐ Full Time Student ☐ Part Time Student ☐ Employed

VISION INSURANCE INFORMATION

Name and Address of Secondary Insurance Company _____ City _____ State _____ Zip _____

M ☐ F ☐ Insured's First Name _____ MI _____ Insured's Last Name _____

Insured's Identification Number _____ Group Number _____ Insured's Date of Birth _____

Patient Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Please Read:

The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. All copays and non-insurance bills are due at the time services are rendered. It is the patient's responsiblity to know his/her insurance benefits. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks. Payment from medical and vision insurance is to be paid directly to Lunette Boston, PC. **My medical insurance will be billed for my optomap retinal photo, if I have an unmet deductible** I will be charged for the retinal photos. My vision insurance will be billed for my routine eye exam. There is an additional fee for **CONTACT LENS EVALUATION OR FITTING ($85 and up). All medical visits require a referral if insured by an HMO, this is the patient's responsibility to get the referral. It is the patient's responsibility to have a REFERRAL for any MEDICAL visit, if required by your HMO**. I understand that all insurance benefits quoted to me are not a guarantee of payment by my insurance company and that final determination will be made when the claim is processed by my insurance co. This office abides by HIPAA. I have seen a copy of the HIPAA policy.

Signature_____Date_____

Name

Lunette Boston, PC
PATIENT HISTORY AND INFORMATION

PRIMARY CARE PHYSICIAN

Primary Care Physician and Clinic Name

Address of Primary Care Physician City State Zip Phone

REFERRING PHYSICIAN

Referring Physician and Clinic Name

Address of Referring Physician City State Zip Phone

HEALTH HISTORY

What is the main reason for today's exam ? When was your last exam ?

When was your last health exam ?

Past Illnesses or Injuries:

Past Surgeries:

Current Medications:

Current Eye Drops:

Medicines that cause reactions or sensitivities:

Specific Allergies:

EYE HISTORY

Glaucoma	○ Yes ○ No	Dryness	○ Yes ◉ No	Strabismus (Crossed Eyes)	○ Yes ◉ No
Cataract	○ Yes ◉ No	Excess Tearing/Watering	○ Yes ◉ No	Blurred Vision Distance	○ Yes ◉ No
Macular Degeneration	○ Yes ◉ No	Eye Pain or Soreness	○ Yes ◉ No	Blurred Vision Near Distorted	○ Yes ◉ No
Retinal Detachment	○ Yes ◉ No	Foreign Body Sensation	○ Yes ◉ No	Vision (halos)	○ Yes ◉ No
Color Blindness	○ Yes ◉ No	Infection of Eye or Lid	○ Yes ◉ No	Double Vision	○ Yes ◉ No
Headaches	○ Yes ◉ No	Itching	○ Yes ◉ No	Floaters or Spots	○ Yes ◉ No
Tired Eyes	○ Yes ◉ No	Mucous Discharge	○ Yes ◉ No	Fluctuating Vision	○ Yes ◉ No
Glare/Light Sensitivity	○ Yes ○ No	Drooping Eyelid	○ Yes ◉ No	Loss of Vision	○ Yes ◉ No
Burning	○ Yes ◉ No	Redness	○ Yes ◉ No	Loss of Side Vision	○ Yes ◉ No
Amblyopia (Lazy Eye)	○ Yes ◉ No	Sandy or Gritty Feeling	○ Yes ◉ No		

GENERAL HEALTH CONDITION

Fever	○ Yes ◉ No	Respiratory (Asthma)	○ Yes ◉ No	Anxiety or Depression	○ Yes ◉ No
Weight Loss	○ Yes ◉ No	Gastrointestinal	○ Yes ◉ No	Thyroid, Diabetes	○ Yes ◉ No
Other Symptoms	○ Yes ◉ No	Kidney	○ Yes ◉ No	Blood/Lymph	○ Yes ◉ No
Ears,Nose,Throat	○ Yes ◉ No	Muscles,Bones,Joints	○ Yes ◉ No	Allergic	○ Yes ◉ No
Cardiovascular (high blood pressure etc.)	○ Yes ◉ No	Skin	○ Yes ◉ No	Pregnant	○ Yes ◉ No
		Neurological (Multiple Sclerosis)	○ Yes ◉ No	Nursing	○ Yes ◉ No

FAMILY HISTORY

Amblyopia (Lazy Eye)	○ Yes ◉ No	Retinal Detachment	○ Yes ◉ No	High Blood Pressure	○ Yes ◉ No
Blindness	○ Yes ◉ No	Strabismus (Eye Turn)	○ Yes ◉ No	Kidney Disease	○ Yes ◉ No
Cataract(s)	○ Yes ◉ No	Arthritis	○ Yes ◉ No	Lupus	○ Yes ◉ No
Color Blindness	○ Yes ◉ No	Cancer	○ Yes ◉ No	Stroke	○ Yes ◉ No
Glaucoma	○ Yes ◉ No	Diabetes	○ Yes ◉ No	Thyroid Disease	○ Yes ◉ No
Macular Degeneration	○ Yes ◉ No	Heart Disease	○ Yes ◉ No	Others	○ Yes ◉ No

Name

Lunette Boston, PC

MEDICAL HISTORY QUESTIONAIRE

SOCIAL HISTORY

Current Occupation : _____ Years _____ Employer _____

SPECTACLE LENS HISTORY

Do you use a computer? ○ Yes ◉ No How many hours/day? _____ Distance from Computer? _____

Do you drive? ○ Yes ◉ No Mileage to work each way? _____

Do you have glare problems? ○ Yes ◉ No

Do you have visual difficulty when driving? ○ Yes ◉ No

Do you have problems with night vision? ○ Yes ◉ No

Do you currently wear glasses ? ○ Yes ◉ No Since _____

Type of glasses ☐ FullTime ☐ PartTime ☐ Distance ☐ Close

Glasses Owned ☐ SingleVision ☐ Bifocals ☐ Trifocals ☐ Backup ☐ Safety ☐ Sports ☐ Progressive

Have you had trouble in the past with glasses? ○ Yes ○ No _____

Do you wear sunglasses? ○ Yes ○ No Are your sunglasses your current prescription? ○ Yes ○ No

☐ Computer (special prescriptions, special anti-glare tints or coatings) ☐ Safety Glasses (gardening, woodworking, welding)
☐ Occupational (mechanics, plumbers, pilots) ☐ Sports/Hobbies (racquet sports, motorcycle)

CONTACT LENS HISTORY

Per MA state law, contact lens RX expire yearly. Do you need CL RX today? ($85+) ○ Yes ○ No

Have you ever tried to wear contact lenses? ○ Yes ○ No Reason for stopping? _____

Do you currently wear contact lenses? ○ Yes ○ No Since _____

Type and brand of contact lenses _____ Today's wearing time ? _____

How many hours/day ? _____ How many days/week ? _____

Please rate the following on a scale of 1-10, with 1 being POOR to 10 being EXCELLENT

	Right	Left		Right	Left		Right	Left
Lens Comfort	_____	_____	Distance Vision	_____	_____	Near Vision	_____	_____

What Solutions do you use? Cleaner _____ Disinfectant _____ Enzyme _____

SOCIAL HISTORY

Do you use nutritional supplements (vitamins etc.)? ○ Yes ◉ No

Do you engage in regular exercise? ○ Yes ◉ No

Do you drink alcohol ? If yes, how much/often : ◉ No ○ Occasional ○ 1 Per Day ○ 2-3/day ○ 4+/day

Do you smoke ? If yes, how much/often : ◉ No ○ Occasional ○ 1/2 pack/day ○ 1 pack/day ○ 1+ pack

Method of Tobacco Intake : ○ Smoking ◉ Chewing

Do you use Illegal Drugs : ○ Yes ◉ No

Hobbies/ Interests : _____