Nolte Eye Care 317-486-9427

Guardian: _____ **Date:** 1/9/25

Name: _____ _____

Address: _____

City, St: _____ **Zip:** _____

Phone(Cell): _____ **(H):** _____

Date of Birth: _____ **Sex:** ____

Vision or Primary Insurance

Ins.: _____ **#:** _____

Insured: _____ **DOB:** _____

Relationship:

Medical or Secondary Insurance

Ins.: _____ **#:** _____

Insured: _____ **DOB:** _____

Relationship:

E-Mail: _____

Notify me by: ☐ Text ☐ Phone ☐ Email ☐ Mail

Referred by (name of friend we can thank)

☐ Friend ☐ Insurance ☐ Phone Book ☐ Other…

Medical Doctor(s):

Approx. Date of Last Eye Exam:

Glasses R-
L-

Contacts R-
L-

Drug Allergies
- ☐ None
- ☐ Penicillin
- ☐ Sulfa
- ☐ Eye drops
- ☐ Other…

Current Medicines

Race **Ethnicity** **Language**

History or Problems

☐ Allergy	☐ Heart disease	☐ Thyroid
☐ Amblyopia	☐ High B.P.	☐ Other…
☐ Cataract	☐ Keratoconus	
☐ Crossed Eyes	☐ Kidney	
☐ Diabetes II	☐ Lazy Eye	
☐ Droopy Lid	☐ Macular Degen.	
☐ Ear	☐ Migraine	
☐ Eye Infection	☐ MS	
☐ Eye Injury	☐ Sinusitis	

Eye wear History (have you ever worn...)

☐ Glasses	☐ Soft Contacts	☐ Monovision
☐ Bifocals	☐ Toric Soft	☐ Disposable
☐ Trifocals	☐ Gas Perm	☐ Overnight wear
☐ No- line	☐ Hard	☐ Other…

Family History (parents, grandparents, siblings)

☐ Blindness	☐ Macular Degen.	☐ Glaucoma
☐ Cataracts	☐ Retina Disease	☐ Cancer
☐ Crossed Eyes	☐ Retina Detach	☐ None
☐ Color Blind	☐ Heart Disease	☐ Other…
☐ Diabetes	☐ High B.P.	
☐ Kidney Disease	☐ Thyroid	

Social History **Occupation** _____

☐ Computer	☐ Golf	☐ Drug Abuse
☐ Reading	☐ Fishing	☐ Alcohol Abuse
☐ Student	☐ Tennis	☐ No alcohol or drug abuse
☐ Music	☐ Swim	☐ Other…
☐ Skiing	☐ Bike	

◯ 1 Current everyday smoker	◯ 4 Never smoker
◯ 2 Current some day smoker	◯ 5 Smoker, current status unknown
◯ 3 Former smoker	◯ 9 Unknown if ever smoked

Current eye problem(s) (please check the "main" problem)

☐ Blur at Far	☐ Flashes/Floaters
☐ Blur at Near	☐ Loss of vision
☐ Blur at Far & Near	☐ Double vision
☐ Itching	☐ Sandy/Gritty
☐ Burning	☐ Spots or shadows
☐ Redness	☐ Diabetes eye check
☐ Eye pain	☐ Medical eye check
☐ Eye strain	☐ Other…

Release of Information

I authorize the staff at AEC to discuss my medical health findings, prescriptions, and bills with the following people:

1.
2.
3.

Our office requires payment at the time of service unless payment arrangements have been approved in advance by our office staff. We will be happy to file for insurance reimbursement; however, any monies remaining owed beyond this will be due from you, as the financial responsibility for your visit is ultimately yours. **We require a 24 hour cancellation notice.** Contact lens fittings and follow up care are billed separately from your Routine Eye Exam. Special testing and medical exxams are not considered routine care and will be billed through major medical insurance. A copy of "Notice of Privacy Practices" is available at your request.

Remind me of my appointment by: ☐ Text

Signature_____ Date_____

Relationship to Patient _____