Drs. James & Enyart Optometrists, S.C.

Your Vision Source Headquarters

Oregon Clinic
185 W. Netherwood St.
Oregon, WI 53575
P: (608) 835-3579
F: (608) 400-0290

Monona Clinic
700 River Place
Madison, WI 53716
P: (608) 223-0202
F: (608) 440-8220

www.jamesandenyart.com
jamesandenyart@gmail.com

Please fill out **BOTH SIDES** completely and provide a copy of your insurance card.

Check **ALL** that apply:

☐ Mr.	☐ Married	☐ Full Time	☐ Student	☐ Male
☐ Mrs.	☐ Single	☐ Part Time	☐ Not Employed	☐ Female
☐ Ms. / Miss	☐ Other	☐ Retired	☐ Homemaker	

Name ____ Date of Birth ______/______/______
(First, Middle, Last)

Preferred Name ___________________________ Age ________ SSN ___________________________

Address ____
(Street, City, State, Zip)

C Phone (______)______________ **H** Phone (______)______________ **W** Phone (______)______________

Preferred Phone - Please circle: **Cell / Home / Work**

E-Mail ____

Employer / School ___________________________________ Occupation ___________________________

Ethnicity ____________________ Preferred Language ________________ Responsible Party ______________
(Self / Parent / Guardian Name **)**

Insurance Information - Please Fill Out Completely

We bill according to the doctor's diagnosis; vision versus medical insurance.

Vision Insurance Company ______________________ Medical Insurance Company ______________________

Primary Care Provider Name ____________________________ Clinic Location________________________

Authorization & Release

I authorize release of any information concerning my (or my child's) healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly, to be paid directly to the doctor and that any **denied services, deductibles and/or co-pays** will be billed to me and I am responsible for their payment.

____ ____________________________________
(Signature of Patient / Parent / Guardian) (Date)

(CONTINUE ON BACK)

Do you currently wear: **Glasses** **Yes / No** **Contact Lenses** **Yes / No** **Readers** **Yes / No**

(please circle)

For clinic – RX:	OD:
	OS:

Vision History

Have you had a recurring issue with any of the following? ***(Answer each)***

Sandy or Gritty	Yes / No	Glaucoma	Yes / No	Loss of Peripheral Vision	Yes / No
Itchy	Yes / No	Loss of Vision	Yes / No	Double Vision	Yes / No
Burning	Yes / No	Blurred Vision	Yes / No	Dryness	Yes / No
Foreign Body Sensation	Yes / No	Fluctuating Vision	Yes / No	Mucous Discharge	Yes / No
Excess Tearing	Yes / No	Distorted Vision	Yes / No	Redness	Yes / No
Glare / Light Sensitivity	Yes / No	Tired Eyes	Yes / No	Lazy / Crossed Eye	Yes / No
Pain or Soreness	Yes / No	Drooping Eyelid	Yes / No	Retinal Detachment	Yes / No
Infection	Yes / No	Cataracts	Yes / No	Macular Degeneration	Yes / No
Flashes / Floaters	Yes / No	Eye Surgeries	Yes / No	Eye Injury	Yes / No

Medical Information

Current Smoker Yes / No **Former Smoker** Yes / No **Chewing Tobacco** Yes / No **Allergy to Latex** Yes / No

Do you use alcohol? Yes / No **Height** _________________ **Weight** _________________

Do you have any of these health issues in any of these systems?

Cancer	Yes / No	Ears / Nose / Throat	Yes / No	Nervous	Yes / No
Headaches	Yes / No	Mental	Yes / No	Cardiovascular	Yes / No
High Blood Pressure	Yes / No	Gastrointestinal	Yes / No	Urinary	Yes / No
Muscles / Bones	Yes / No	Respiratory	Yes / No	Skin	Yes / No
Endocrine (Glands)	Yes / No	Blood / Lymph	Yes / No	Allergy / Immunologic	Yes / No

Family and Personal History (Please note **WHO** (Self, Mother, Father, Brother, Sister, Son and/or Daughter) for **ALL**)

Cancer ____ Diabetes I or II ____

High Blood Pressure ______________________________ Thyroid (Hyper or Hypo) ______________________________

Cataracts _______________________________________ Glaucoma ____

Macular Degeneration _____________________________ Retinal Detachment ____________________________________

Medications (include non-prescription, vitamins, herbal supplements) Name & Dosage:

____

____

Allergies to Medications ____

Type of Reaction ____