



DR. JEFFREY ZIGULIS

Optometrist

ADVANCED EYE CARE • 229 Tecumseh Road • Dundee, MI 48131 • (734) 529-8747

ADVANCED EYE CARE • 3409 Sterns Road • Lambertville, MI 48144 • (734) 856-7070

Welcome To Our Office

Name _____
 Street _____
 City _____ State _____ Zip _____
 Parent or Guardian _____
 Phone: Home _____ Work _____
 Social Security Number _____
 Employer _____
 Occupation _____
 Hobbies _____
 Email Address _____
 Contact by email? Yes No _____

Today's Date _____ Date of Last Exam _____

Date of Birth _____ Age _____ Sex: M F

Insurance Information (must be completed to file any claims)

Vision Plan _____ Medical Ins. Co. _____

Name of Insured _____

Insured's Employer _____ Group # _____

Insured's Date of Birth _____ and ID# _____

Patient's relationship to insured: Self Spouse Child Other

Patient's Marital Status: Single Married Other

Personal Medical History: Do you have?

Allergic to meds	Yes	No	Eye Disorder(s)	Yes	No
Arthritis	Yes	No	Fibromyalgia	Yes	No
Asthma	Yes	No	Heart Disease	Yes	No
Cancer	Yes	No	High Blood Pressure	Yes	No
Depression	Yes	No	Migraines	Yes	No
Digestive Disorder	Yes	No	Neurologic Disorder	Yes	No
Diabetes	Yes	No	Skin Disorder	Yes	No

Current Medications (Rx & Over the Counter)

Name of Medication	Reason for Taking
_____	_____
_____	_____
_____	_____
_____	_____

Oral Contraceptive Yes No Eye Drops Yes No

List any medications you are allergic to: _____

Name of family doctor: _____

How did you hear about our office?

- Friend or relative. Who? _____
- Another health care practitioner. Who? _____
- Yellow pages. _____
- Newspaper advertisement. _____
- Radio advertisement. _____
- Insurance list. _____
- Other? _____

Consent & Authorization to Release Information

I herby authorize treatment and the release of any information or photographs acquired in the course of my examination or treatment, to my referring doctor or insurance company as necessary.

I understand that I am financially responsible for services and materials provided to me at Advanced Eye Care the offices of Zigulis Eye Care, Inc.

Signature: _____ Date _____

Family Medical History: Do Family Members Have?

Diabetes	Yes	No	Cataract	Yes	No
Ocular Tumors	Yes	No	Glaucoma	Yes	No
High Blood Pressure	Yes	No	Macular Degeneration	Yes	No
Blindness	Yes	No	Retinal Detachment	Yes	No

Please list any complaints about wearing glasses or contact lenses

Do you have more than 1 pr. of current Rx glasses? Yes No

Do you work on a computer for long periods? Yes No

Would you benefit from thinner, lighter lenses? Yes No

Do you spend a lot of time outdoors? Yes No

Do you have difficulty driving at night? Yes No

Are there times you would rather not wear glasses? Yes No

If you wear bifocals, are you bothered by restricted windows, lines or head tilting? Yes No

Are you interested in a "test drive" of the latest in contact lens design(s)? Yes No

Would you like to learn about laser vision correction? Yes No

Do You Experience...

Any discomfort with your eyes? Yes No

Problems with glare or reflection? Yes No

Sensitivity to light? Yes No

Headaches? Yes No

Floaters or flashes of light? Yes No

Double vision? Yes No

I have read and I understand the privacy policies and have received a copy.

Signature: _____ Date _____