WELCOME TO OUR OFFICE!

Please complete this form to the best of your knowledge. The information you give will enable us to provide you with complete, quality eye care.

GENERAL INFORMATION:

Today's Date _____ / _____ / _____

Mr. Mrs. Miss Ms. Dr.

Patient Name _____ Social Security # _____
FIRST MIDDLE INITIAL LAST

How do you wish to be addressed? (e.g. - Mr., 1st Name, Nickname) _____

Home Address _____
STREET CITY STATE ZIP

Home Phone Number _____ Work # _____ Date of Birth _____ / _____ / _____

Cell # _____ Your Email Address: _____

Your Occupation _____ Employer/School _____

Spouse's Name _____ Employer _____ Work # _____

If a Minor, Parent's Names: Father _____ Employer _____ Work # _____

Mother _____ Employer _____ Work # _____

FAMILY MEMBERS:

Name Age

_____

_____

_____

_____

How did you first hear about our office?

- ☐ Friend or Relative – Who? _____
- ☐ Another Health Care Practitioner – Who? _____
- ☐ Yellow Pages ------ which directory? _____
- ☐ Newspaper Advertisement ☐ Radio Advertisement
- ☐ Civic Group or Community Event – Which? _____
- ☐ Previous Patient – Who? _____
- ☐ Other _____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Name _____ Relationship _____

Address _____ Home Phone (____) _____

_____ Work Phone (____) _____

Insurance Company Name _____

Policy Holder _____ Group # _____ I.D. # _____

How will you settle your account today? ☐ **Check** ☐ **Cash** ☐ **Credit Card** ☐ **Insurance**

PAYMENT POLICY

Full payment is required at the time services are rendered. If you have any of the following insurance carriers, only the payment of uncovered services will be expected on the day of examination. Those carriers include Medicare, Medicaid, Blue Cross/Blue Shield, and Preferred Health. If your insurance carrier is not included in the previous list, payment of all services is expected at the time service is rendered. Your insurance is a contract between you, your employer, and the insurance company. We are not party to that contract. As a courtesy to those patients whose insurance carrier is not on the previous list, we will be glad to file your primary insurance claim on your behalf and you will be reimbursed based upon insurance payment of covered services. In the event that an account is turned over to collections a fee equal to the amount charged by the collections company/attorney may be assessed.

ONE TIME AUTHORIZATION - SIGNATURE ON FILE _____

I request that payment of authorized Insurance benefits be made either to me or on my behalf to Eyecare Associates for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

X _____ _____ _____

Patient or Primary Insured's Signature | Primary Insured's Birthdate | Date Signed

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and have been provided an opportunity to review it.

X _____ _____

Signature of Patient or Guardian | Date Signed

** Please turn this form over and complete side two**

What is the major purpose of this visit? _____

When was your last eye exam? _____

Do you wear glasses? ❑ no ❑ yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? ❑ no ❑ yes If yes, how old is your present pair of lenses? _____

Type of contact lenses: ❑ Rigid ❑ Soft ❑ Disposable ❑ Other Are they comfortable? ❑ yes ❑ no

Any problems with your present glasses or contact lenses? _____

Are you interested in contact lenses? ❑ yes ❑ no

Are you interested in purchasing new glasses? ❑ yes ❑ no

Are you interested in learning about laser vision correction? ❑ yes ❑ no

Do You . . . . .

Work at a computer for long periods? ❑ Yes ❑ No

Have more than one pair of glasses? ❑ Yes ❑ No

Want information on thinner, lighter lenses? ❑ Yes ❑ No

Have family members in need of eyecare? ❑ Yes ❑ No

Have prescription sunglasses? ❑ Yes ❑ No

Have problems with glare or reflection, particularly when driving at night? ❑ Yes ❑ No

Name of Medical Doctor: _____

FAMILY HISTORY

Do any medical or eye diseases run in your family? If yes, please note disease and relationship to patient.

❑ Blindness _____

❑ Cataract _____

❑ Diabetes _____

❑ Glaucoma _____

❑ High Blood Pressure _____

❑ Macular Degeneration _____

❑ Other: _____

REVIEW OF SYSTEMS

Do you currently have any of the following problems? If yes, please circle or explain:

1. Please list **any** medications you are taking, including eye drops and/or over-the-counter medication.	1. 2. 3. 4. 5. 6. 7. 8.	
2. Do you have any allergies to any medication?	☐ Yes ☐ No	
3. **Constitutional** (fever, weight loss, other)	☐ Yes ☐ No	
4. **Eyes** (glaucoma, cataract, lazy eye, retina problems, loss of vision, dryness, discharge, redness, itching, burning, watering, eye pain, flashes/floaters, other - please specify)	☐ Yes ☐ No	
5. **Ear/nose/throat/mouth** (hearing loss, sinus problems, sore throat)	☐ Yes ☐ No	
6. **Cardiovascular** (heart problems, chest pain, irregular heart beat)	☐ Yes ☐ No	
7. **Respiratory** (asthma, shortness of breath, wheezing, coughing)	☐ Yes ☐ No	
8. **Gastrointestinal** (heartburn, abd. Pain, diarrhea, vomiting)	☐ Yes ☐ No	
9. **Genitourinary** (urinary problems, blood in urine, pregnant, nursing)	☐ Yes ☐ No	
10. **Musculoskeletal** (muscle aches, joint pain, swollen joints)	☐ Yes ☐ No	
11. **Integumentary** (skin rashes, excessive dryness)	☐ Yes ☐ No	
12. **Neurological** (headaches, numbness, weakness, paralysis)	☐ Yes ☐ No	
13. **Psychiatric** (depression, anxiety)	☐ Yes ☐ No	
14. **Endocrine** (diabetes, thyroid problems)	☐ Yes ☐ No	
15. **Hematologic/Lymphatic** (blood disorders, leukemia)	☐ Yes ☐ No	
16. **Allergic/Immunologic** (hay fever, allergies)	☐ Yes ☐ No	

OFFICE USE ONLY:

Reviewed: Dr. _____ Date: _____