1 PATIENT INFORMATION

Date ______

Patient ______

Address ______

City ______ State ______ Zip ______

Sex: ❐ M ❐ F Age ______ Birthdate ______

❐ Single ❐ Married ❐ Widowed ❐ Separated ❐ Divorced

Patient SS # ______

Occupation ______

Employer ______

Employer Address ______

Employer Phone ______

Spouse's Name ______

Birthdate ______ SS # ______

Occupation ______

Spouse's Employer ______

Spouse's Work Phone ______

Whom may we thank for referring you? ______

2 INSURANCE

Who is responsible for this account? ______

Relationship to Patient ______

Insurance Co. ______

Group # ______

Is patient covered by additional insurance? ❐ Yes ❐ No

Subscriber Name ______

Birthdate ______ SS # ______

Relationship to Patient ______

Insurance Co. ______

Group # ______

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with ______ and assign directly to Dr. ______ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature ______

Relationship ______ Date ______

3 PHONE NUMBERS

Home ______ Work ______ Ext ______ Cell Phone ______

Best time and place to reach you ______ Email Address ______

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name ______ Relationship ______

Home Phone ______ Work Phone ______

4 MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. ______ for any services furnished me by that doctor. 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 or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

______ Signature of Beneficiary

______ Date

– OVER –

5 EYE HEALTH HISTORY

Physician's Name ____________________

Date of last visit ____________________

Date of last eye exam? ____________________

Name of doctor ____________________

Do you wear glasses? ❒ Yes ❒ No

❒ All the time ❒ Occasionally
❒ Reading ❒ Driving ❒ TV

Do you wear contacts? ❒ Yes ❒ No

Type ______________ Hours/Day ________

Describe any problems you have with your contacts: ____________________

Place a check on the "Yes" or "No" to indicate if you have had any of the following:

Condition	Yes	No	Condition	Yes	No
Bloodshot Eyes	❒ Yes	❒ No	Floaters or Spots	❒ Yes	❒ No
Blurred Vision - Distance	❒ Yes	❒ No	Glaucoma	❒ Yes	❒ No
Blurred Vision - Near	❒ Yes	❒ No	Headaches	❒ Yes	❒ No
Burning Eyes	❒ Yes	❒ No	Itching Eyes	❒ Yes	❒ No
Cataracts	❒ Yes	❒ No	Light Sensitive	❒ Yes	❒ No
Color Vision, Poor	❒ Yes	❒ No	Loss of Vision	❒ Yes	❒ No
Crossed Eyes	❒ Yes	❒ No	Macular Degeneration	❒ Yes	❒ No
Discharge from Eyes	❒ Yes	❒ No	Night Vision, Poor	❒ Yes	❒ No
Dizzy Spells	❒ Yes	❒ No	Red Eyes	❒ Yes	❒ No
Double Vision	❒ Yes	❒ No	Seeing Halos	❒ Yes	❒ No
Dry Eyes	❒ Yes	❒ No	Seeing Flashes	❒ Yes	❒ No
Eye Infection	❒ Yes	❒ No	Temporary Loss of Vision	❒ Yes	❒ No
Eye Injury	❒ Yes	❒ No	Twitching Eyelid	❒ Yes	❒ No
Eye Strain	❒ Yes	❒ No	Vision Poor	❒ Yes	❒ No
Fainting Spells, Blackouts	❒ Yes	❒ No	Watering Eyes	❒ Yes	❒ No

6 HEALTH HISTORY

Place a check on "Yes" or "No" to indicate if you have had any of the following. Also place a check to indicate if a blood relative has had any of the following problems.

Condition	Yourself		Family Members		Condition	Yourself		Family Members	
AIDS/HIV	❒ Yes	❒ No	❒ Yes	❒ No	Hepatitis (Type ______)	❒ Yes	❒ No	❒ Yes	❒ No
Arthritis	❒ Yes	❒ No	❒ Yes	❒ No	High Blood Pressure	❒ Yes	❒ No	❒ Yes	❒ No
Artificial Heart Valve	❒ Yes	❒ No	❒ Yes	❒ No	Kidney Disease	❒ Yes	❒ No	❒ Yes	❒ No
Artificial Joints	❒ Yes	❒ No	❒ Yes	❒ No	Lazy Eye	❒ Yes	❒ No	❒ Yes	❒ No
Asthma	❒ Yes	❒ No	❒ Yes	❒ No	Lupus	❒ Yes	❒ No	❒ Yes	❒ No
Bleeding	❒ Yes	❒ No	❒ Yes	❒ No	Migraine Headaches	❒ Yes	❒ No	❒ Yes	❒ No
Blindness	❒ Yes	❒ No	❒ Yes	❒ No	Pacemaker	❒ Yes	❒ No	❒ Yes	❒ No
Cancer	❒ Yes	❒ No	❒ Yes	❒ No	Poor Color Vision	❒ Yes	❒ No	❒ Yes	❒ No
Cataracts	❒ Yes	❒ No	❒ Yes	❒ No	Retinal Disease	❒ Yes	❒ No	❒ Yes	❒ No
Chemical Dependency	❒ Yes	❒ No	❒ Yes	❒ No	Rheumatic Fever	❒ Yes	❒ No	❒ Yes	❒ No
Diabetes	❒ Yes	❒ No	❒ Yes	❒ No	Shingles	❒ Yes	❒ No	❒ Yes	❒ No
Drug Sensitivity	❒ Yes	❒ No	❒ Yes	❒ No	Skin Conditions	❒ Yes	❒ No	❒ Yes	❒ No
Emphysema	❒ Yes	❒ No	❒ Yes	❒ No	Stroke	❒ Yes	❒ No	❒ Yes	❒ No
Epilepsy	❒ Yes	❒ No	❒ Yes	❒ No	Thyroid Conditions	❒ Yes	❒ No	❒ Yes	❒ No
Eye Surgery	❒ Yes	❒ No	❒ Yes	❒ No	Tuberculosis	❒ Yes	❒ No	❒ Yes	❒ No
Glaucoma	❒ Yes	❒ No	❒ Yes	❒ No	Turned Eye	❒ Yes	❒ No	❒ Yes	❒ No
Hay Fever	❒ Yes	❒ No	❒ Yes	❒ No					
Heart Condition	❒ Yes	❒ No	❒ Yes	❒ No					

Are you pregnant? ______________ Number of children ______________

Tobacco use ______________ Alcohol use ______________

7 REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas: (if YES, please explain.)

SYSTEM

INTEGUMENT (skin) ❒ Yes ❒ No

NEUROLOGIC
- Headaches ❒ Yes ❒ No
- Migraines ❒ Yes ❒ No
- Seizures ❒ Yes ❒ No

EAR, NOSE, MOUTH & THROAT
- Allergies ❒ Yes ❒ No
- Sinus Congestion ❒ Yes ❒ No
- Chronic Cough ❒ Yes ❒ No
- Dry Throat / Mouth ❒ Yes ❒ No

RESPIRATORY
- Asthma ❒ Yes ❒ No
- Chronic Bronchitis ❒ Yes ❒ No
- Emphysema ❒ Yes ❒ No

LYMPHATIC/HEMATOLOGIC
- Anemia ❒ Yes ❒ No
- Bleeding Problems ❒ Yes ❒ No

PSYCHIATRIC ❒ Yes ❒ No

VASCULAR
- Diabetes ❒ Yes ❒ No
- Heart Pain ❒ Yes ❒ No
- High Blood Pressure ❒ Yes ❒ No
- Vascular Disease ❒ Yes ❒ No

GASTROINTESTINAL
- Diarrhea ❒ Yes ❒ No
- Constipation ❒ Yes ❒ No

GENITOURINARY

Genitals / Kidney / Bladder ❒ Yes ❒ No

BONES / JOINTS / MUSCLES
- Rheumatoid Arthritis ❒ Yes ❒ No
- Muscle Pain ❒ Yes ❒ No
- Joint Pain ❒ Yes ❒ No

ENDOCRINE
- Thyroid / other glands ❒ Yes ❒ No

EXPLAIN ____________________

8 MEDICATIONS

List medications you are currently taking, including eye drops:

____

Pharmacy Name ____________________ Phone ______________

ALLERGIES

List your allergies to medications or other substances:

____