Patient Information Form

Today's Date: _____

Patient Information	Person Responsible for Payment
Last: _____	**Last: _____**
First: _____ MI: _____	**First: _____ MI: _____**
Street: _____	**Street: _____**
City: _____ State: _____	**City: _____ State: _____**
Zip Code: _____	**Zip Code: _____**
Home Phone: _____	**Home Phone: _____**
Cell/Day Phone: _____	**Cell/Day Phone: _____**
Patient's SSN: _____	**SSN: _____**
Employer (or School): _____	**Employer: _____**
_____	**_____**
Occupation (or Grade): _____	**Occupation: _____**
Mr. Mrs. Ms. Miss Dr.	**Mr. Mrs. Ms. Miss Dr.**
Married Single Widowed Divorced	**Married Single Widowed Divorced**
Date of Birth: _____ Age: _____	**Date of Birth: _____ Age: _____**
Sex: M F	**Sex: M F**
Email Address: _____	**Email Address: _____**

Race: □ American Indian □ Asian □ Black or African American □ Hispanic □ Caucasian
Ethnicity: □ Hispanic or Latino □ Pacific Islander □ Not Hispanic
Preferred Language: □ English □ Spanish □ French □ Japanese

Who may we thank for referring you? _____
How did you hear about us? □ Insurance Directory □ Yellow Pages □ Website □ Other

Vision History

What is the PRIMARY reason for your visit today? _____
_____
When was your last eye exam? _____ With Whom? _____
Do you wear glasses? Y N □ Near Vision □ Distance Vision □ Multifocal
Are you having difficulty with your current prescription? _____

Do you wear contact lenses? □ Yes □ No Type? □ Rigid □ Soft □ Distance □ Multifocal □ Monovision
How often do you replace your lenses? _____
Do you wear contacts every day or for recreational use? _____
Brand of disinfectant: _____ Any Issues? _____

Are you interested in finding out if you are a candidate for LASER refractive surgery (LASIK, PRK)? □ Yes □ No

Are you currently experiencing any of the following?

□ Itchy Eyes	**□ Dry Eyes**	**□ Eye Pain**
□ Watering/ Discharge	**□ Headaches**	**□ Eye Allergies**
□ Double Vision	**□ Loss of Vision/ Blurred**	**□ Floaters in Vision**
□ Glare/ Excess Light Sensitivity	**□ Other**	

Name: _____ Date: _____ DOB: _____

Medical History

Medical Doctor: _____ Last Visit Date: _____
Endocrinologist: _____ Last Visit Date: _____
Other Eye Specialists: _____ Last Visit Date: _____Reason? _____
***Please indicate if any of the following medical conditions pertains to you**

Allergic/ Immune:	**Eyes:**	**Endocrine:**
Environmental Allergy ☐	Glaucoma ☐	Type 1 Diabetes ☐
Seasonal Allergy ☐	Cataract ☐	Type 2 Diabetes, Oral ☐
Food Allergy ☐	Macular Degeneration ☐	Type 2 Diabetes Insulin ☐
_____	Flashes/Floaters ☐	Diagnosis Date: _____
Drug Allergy ☐	Inflammation ☐	Last A1c :_____
_____	Blurry Vision ☐	Thyroid Dysfunction ☐
HIV/ AIDS ☐	Double Vision ☐	Hormonal Dysfunction ☐
Lyme Disease ☐	Lazy Eye ☐	
Sjogren's Syndrome ☐	Dry ☐	
	Color Blindness ☐	
Cardiovascular:	**Gastrointestinal:**	**Nervous System:**
Heart Disease ☐	Crohn's Disease ☐	Multiple Sclerosis ☐
High Blood Pressure ☐	Colitis ☐	Epilepsy ☐
Stroke ☐	Ulcer ☐	Parkinson's ☐
Vascular Disease ☐	Digestive ☐	Migraines / Headaches ☐
Other ☐	Other ☐	Traumatic Brain Injury ☐
Cholesterol ☐		
Constitutional:	**Genitourinary:**	**Respiratory:**
Developmental ☐	Genital/ Prostate ☐	Asthma ☐
Weight Loss ☐	Kidney/ Bladder ☐	Emphysema ☐
Persistent Fever ☐	Ovary/Uterus ☐	Sleep Apnea ☐
Chronic Fatigue ☐	STD: _____ ☐	COPD ☐
Trauma ☐	Hormone Therapy ☐	**Psychiatric:**
Dizziness ☐	Currently Pregnant ☐	Anxiety ☐
Other ☐	Breast Feeding ☐	Alzheimer's / Dementia ☐
		Autism ☐
Ears/ Nose/ Throat:	**Blood/ Lymphatic:**	**Social History:**
Dry Mouth/ Throat ☐	Anemia ☐	Current Smoker ☐
Ringing/ Tinnitus ☐	Bleeding Problems ☐	Former Smoker ☐
Difficulty Swallowing ☐	Leukemia ☐	Packs Per Day? _____
Other ☐	Blood Loss ☐	How many years? _____
		Other Tobacco ☐
Musculoskeletal:	**Integumentary/ Skin:**	**Drug Use:**
Fibromyalgia ☐	Eczema ☐	Narcotic Use ☐
Muscular Dystrophy ☐	Rosacea ☐	Recreational Use ☐
Osteoporosis ☐	Psoriasis ☐	Alcohol Use ☐
Ankylosing Spondylitis ☐	Lupus ☐	Drinks Per Day? _____
Rheumatoid Arthritis ☐	Other ☐	

Eye Surgery / Injuries: _____
Cancer or Other Medical Surgery: _____
Current Medications: _____
_____

Date:	**Date:**	**Date:**
Patient Initials:	**Patient Initials:**	**Patient Initials:**

Family History

Has any member of your family had these diseases? (Mother, Father, Grandparent, Sibling)

Disease/Condition	Y	Relationship	Disease/Condition	Y	Relationship
Blindness	☐	______________	Diabetes	☐	______________
Lazy Eye	☐	______________	Heart Disease	☐	______________
Glaucoma	☐	______________	High Blood Pressure	☐	______________
Macular Degeneration	☐	______________	Kidney Disease	☐	______________
Retinal Detachment	☐	______________	Lupus	☐	______________
Cataracts	☐	______________	Thyroid Disease	☐	______________
Rheumatoid Arthritis	☐	______________	Cancer	☐	______________

Insurance

Vision Insurance: __________________________
SS#/ID#: __________________________________
Member Name:_______________DOB: _______
Relationship to Patient: _____________________
Member Address: __________________________
Do you participate in a flex spending account?
☐ Yes ☐ No

Medical Insurance: ________________________
ID#: ______________ Group #: _____________
Member Name:______________ DOB:_______
Relationship to Patient: ___________________
Member Address: ________________________
How will you settle your account today?
☐ Cash ☐ Check ☐ Credit Card

It is my responsibility to provide this office with accurate vision and/or medical insurance information and I authorize this office to submit claims on my behalf. I understand the doctor(s) may or may not be participating with my insurance carrier(s) and I am fiscally responsible for all denials, copayments, coinsurances, or deductibles associated with routine or medical services and/or materials rendered. When a medical claim is being submitted on my behalf I am responsible for obtaining any prior authorizations and referrals needed.

Contact lens evaluation are a separate fee beyond my routine and/or medical comprehensive eye examination and may or may not be covered by my insurance. The contact lens evaluation has unique tests associated to determine fit, health, condition, and clarity of my eyes when wearing contact lenses. A refraction is the part of the exam where the doctor determines my spectacle prescription. This service also may not be covered by my insurance and I will be responsible.

My account will be charged a billing fee for balances over 30 days after insurances have been processed. I will also be charged $30 for any returned checks. If my account is turned over to collection I will cover all collection fees and legal action.

Signature: _____________________________________ Date: __________________________

Acknowledgement of Receipt and General Consent
(This form to serve as a lifetime signature on file)

I have read and/or understood the Notice of Privacy Practices and I further consent to the release of my health information for purposes of treatment, payment and health care operations and as authorized or required by law under the circumstances described in the Notice of Privacy Practices.

Please list to whom you would like your eye records released to: ______________________________
Patient Signature: ___________________________________ Date: __________________________
(Parent or Guardian)
***If you are signing as a personal representative of the patient, parent or guardian please describe your relationship. We ask that an adult please accompany all children to their appointments.**