Day of Exam – Patient Information

Welcome to our office.
To better serve you today, please fill out **BOTH** sides of this form.

Today's Date ___________________

Last Name ____________________________ First Name ____________________ Initial _____
Address ____
City _______________________________ State ________________ ZIP __________________
Home Phone _____________________________ Cell Phone ____________________________
Social Security No. ________________________ Date of Birth __________________________
Employer ________________________________ Occupation __________________________
E-Mail Address ____
Date of Last Eye Exam ____________In our office? No ___ Yes ___
Sex: Male ____ Female ____
Marital Status: Single___ Married___ Widowed___ Divorced___
Height: _____ft _____in
Weight: _______lbs

If you would like a report sent to any of your physicians, include their name and contact information:____

Insurance Information

Is this visit payable by insurance? Yes ___ No ___
If Yes: Name of Insurance ____
Name of Insured Member ____
Where Employed ____
Social Security # of Member _______________________________________
Members birth date ____

AUTHORIZATION TO PAY BENEFITS: I hereby authorize my insurance company to pay all benefits for the services described to The Eyecare Center. I also understand that I am personally responsible for all charges incurred. A copy of this authorization shall be as valid as the original. I have read and understood the general office policies stated below.

Signature of Member _________________________________ Date ________________

General Office Policies

(1) A **non-refundable** deposit is required on all materials ordered. Materials will be held for 30 days after notification for pick-up before being returned to our suppliers, resulting in **LOSS** of deposit. (2) A $25 service charge on all returned checks. (3) No-line Progressive bifocals can be remade within 30 days of dispensing to a standard FT28 bifocal at no additional charge. (4) There are **NO** refunds. (5) Opened vials or boxes of contact lenses **cannot** be exchanged. Only contact lenses purchased in our office may be exchanged. (6) Our office Notice of Privacy Practices as mandated under HIPPA is posted in the reception area of each office. A copy is available at your request at the front desk of each office. (7) Your records will be retained for a period of at least 5 years, as per federal law.

Signature of Patient /Guardian_________________________________ Date ________________
*Must be 18 years or older

COMPLETE NEXT SIDE

Personal Medical Information

Do you HAVE or have you EVER had problems with any of the following? (Circle appropriate ones)

Eyes	Blurred vision, red eye, loss of side vision, double vision, dryness, tearing, redness, itching, burning, glare, halos, sensitivity to light, eye pain
Allergies	Allergic to what? ___
Cardiovascular	Heart problems, high cholesterol, **high blood pressure**, stroke
Constitutional	Appetite loss or excess, blackouts, dizziness, fainting, fever, nausea, vomiting, weakness
Endocrine	**Diabetes**, gout, **thyroid disorder**, **pituitary disorder**
Are You Diabetic?	No___ Yes___ If yes, I take: insulin, pills or both
Gastrointestinal	Ulcer, liver, colitis, gall bladder, hepatitis, reflux, inflammatory bowel syndrome
Genitourinary	Bladder infection, kidney stones, menopause, ovarian, pelvic, prostate, uterine
Cranial/Facial	Sinus congestion, postnasal drip, dry mouth, headache, sinus, ear infection, dry mouth
Hematologic/Lymph	Anemia, breast cancer, clotting disorder, **leukemia**, **sickle cell**, blood disorder
Immunologic	**AIDS**, **HIV positive**, **Sarcoidosis**, **herpes simplex or zoster**, lyme disease, TB, Sjogren's
Integumentary (Skin)	Acne, albinism, dermatitis, hemangioma, **lupus**, vitilago
Musculosceletal	**Arthritis**, Down's syndrome, muscular dystrophy, osteoporosis, **Marfan's syndrome**
Neurological	Bell's palsy, **brain tumor**, epilepsy, headache, Parkinson's, seizure disorder
Psychiatric	ADD, anxiety disorder, bipolar, depression, mentally challenged, schizophrenia
Respiratory	Asthma, bronchitis, cystic fibrosis, COPD, lung disorder, pneumonia, **sarcoidosis**, **TB**
Do You Use Tobacco?	No__ Yes__ Alcohol? No__Yes__ Other substances? No__Yes__

List ALL Medications you are taking: ___

___

___

___

Family Medical History

DOES ANYONE IN YOUR FAMILY HAVE:

High Blood Pressure:	Yes___ No___	Relation: ___
Diabetes:	Yes___ No___	Relation: ___
Glaucoma:	Yes___ No___	Relation: ___
Macular Degeneration	Yes___ No___	Relation: ___
Retinal Detachment	Yes___ No___	Relation: ___
Cataracts:	Yes___ No___	Relation: ___
Other Eye Condition(s):	Yes___ No___	What kind?___

Personal Eye Information

Have you ever been diagnosed with an eye condition other than needing glasses? Yes___ No___ What:___

Have you had any eye operations? Yes___ No___ Type ___ Date ___

Have you had an eye injury? Yes___ No___ Kind ___ When___

Do you have Glaucoma? Yes___ No___ Do you get headaches? Yes___ No___

Do you have Cataracts? Yes___ No___ Do you have dry eyes? Yes___ No___

Do your eyes: burn__ water__ itch__ ache__ tire__

Do you have blurred vision? Yes___ No___ Far away? ___ Up close? ___

Other eye problems? What kind ___

Do you wear glasses? Yes___ No___

Do you wear contact lenses? Yes___ No___ What brand or type___ ___

I certify that none of the above information has changed since my last visit at the Eyecare Center. I agree to authorize my insurance to pay all benefits for services to the Eyecare Center. A Notice of Privacy Practices as mandated under HIPAA was offered to me. I agree to the General Office Policies as previously signed:

Signature:___ Date:___

Print Name:___