Patient Information

Name: _____Today's Date: _____
Address:_____City/State/Zip:_____
Home Phone: _____Cell Phone: _____Work Phone_____
Marital Status: Single ___ Married ___Widowed:____ Other____ Date of Birth:_____
Social Security #:_____ Height _____
Caucasian ____ African American ___Arab ____ Asian____ Hispanic ____Other_____
Spouse Name:_____ Spouse Date of Birth:_____
Email Address: _____

Employment Information: (if minor skip to next section)

Retired: ____Yes _____ No Unemployed: _____ Yes _____No
Employer _____ Work Phone Number _____
Work Address: _____

Responsible Party Information:

Who is responsible for this account (if different from above):

Name:_____
Address:_____City/State/Zip_____
Home Phone: _____Cell Phone: _____Work Phone: _____
Where Employed: _____
Work Address: _____
Responsible Party's Social Security #:_____Date of Birth: _____
If patient is a minor, relationship to patient: _____

Insurance Information:

Primary **Medical** Insurance Company:_____
Identification/Policy #: _____Group #_____
Name of Subscriber (primary person on insurance)_____ DOB_____
Relationship to subscriber: Self _____Spouse _____Child _____Other _____

Secondary **Medical** Insurance Company:_____
Identification/Policy # :_____Group #_____
Name of Subscriber (primary person on insurance)_____ DOB_____
Relationship to subscriber: Self _____Spouse _____Child _____Other _____

Vision Insurance_____
Identification/Policy #: _____
Name of Subscriber (primary person on insurance)_____ DOB_____
Relationship to subscriber: Self _____Spouse _____Child _____Other _____
Does your insurance require a referral from your primary care physician? Yes_____ No_____
**********Please give receptionist your card to copy**********
Who is your primary physician? _____City/State_____
Referring Physician's Name: _____City/State_____
How did you hear about us? ___Word of Mouth ___Phone Book ____Internet (search sites) ___Insurance

Symptoms Checklist

Print Name
Last_____ First_____Date_____

Check Eye Symptoms You Experience (✓):

	Left	Right
Redness	❑	❑
Dry Eye Feeling	❑	❑
Mucous Discharge	❑	❑
Sandy or Gritty Feeling	❑	❑
Itching	❑	❑
Burning	❑	❑
Foreign Body Sensations	❑	❑
Constant Tearing	❑	❑
Occasional Tearing	❑	❑
Watery Eyes	❑	❑
Light Sensitivity	❑	❑
Eye Pain or Soreness	❑	❑
Chronic Infection of Eye or Lids	❑	❑
Stics, Chalazion	❑	❑
Fluctuating Visual Activity	❑	❑
"Tired" Eyes	❑	❑
Contact Lens Discomfort	❑	❑
Contact Lens Solution Sensitivity	❑	❑

Check Any of the Following Symptoms That You Are Having (✓):

Sinus Congestion	❑
Congestion	❑
Post-Nasal Drip	❑
Cough-Chronic	❑
Allergy Symptoms	❑
Seasonal Allergies	❑
Hay Fever Symptoms	❑
Cold Symptoms	❑
Middle Ear Congestion	❑
Sneezing	❑
Dry Throat, Mouth	❑
Headaches	❑
Asthma Symptoms	❑
Arthritis	❑
Joint Pain	❑

Medical History:

Review of Systems: PLEASE CHECK YES OR NO IF THEY DO OR DO NOT PERTAIN TO YOU:

System **Eyes:**	**Yes**	**No**
Glaucoma	☐	☐
Cataract	☐	☐
Macular degeneration	☐	☐
Surgery	☐	☐
Inflammatory disorders	☐	☐
Trauma	☐	☐
Other_____		

System **Constitutional:**	**Yes**	**No**
Developmental disability	☐	☐
Weight loss	☐	☐
Fever	☐	☐
Fatigue	☐	☐
Trauma	☐	☐
Other_____		

Cardiovascular:	**Yes**	**No**
Heart disease	☐	☐
Hypertension	☐	☐
Stroke	☐	☐
Vascular disease	☐	☐
Other _____		

Muskuloskeletal:	**Yes**	**No**
Fibromyalgia	☐	☐
Muscular dystrophy	☐	☐
Osteoarthritis	☐	☐
Ankylosing spondylitis	☐	☐
Other_____		

Endocrine:	**Yes**	**No**
Non-insulin dependant diabetes	☐	☐
Insulin dependant diabetes	☐	☐
Thyroid dysfunction	☐	☐
Hormonal dysfunction	☐	☐
Other_____		

Gastrointestinal:	**Yes**	**No**
Crohn's:	☐	☐
Colitis	☐	☐
Ulcer	☐	☐
Digestive	☐	☐
Other_____		

Respiratory:	**Yes**	**No**
Smoker	☐	☐
Asthma	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
Other_____		

Allergic/Immunologic:	**Yes**	**No**	**None Known**
Drug allergy	☐	☐	
Enviromental allergy	☐	☐	☐
Rheumatoid arthritis	☐	☐	
Lupus	☐	☐	
Other_____			

Please flip over to other side!!!!!!

System **Hematologic/Lymphatic:**	**Yes**	**No**	System **Integumentary:**	**Yes**	**No**
Anemia	☐	☐	Eczema	☐	☐
Large volume blood loss	☐	☐	Rosacea	☐	☐
Leukemia	☐	☐	Psoriasis	☐	☐
Other_____			Other_____		
Neurological:	**Yes**	**No**	**Psychiatric:**	**Yes**	**No**
Multiple sclerosis	☐	☐	Depression	☐	☐
Epilepsy	☐	☐	Panic disorder	☐	☐
Other_____			Schizophrenia	☐	☐
			Other_____		
Ears, Nose, Mouth & Throat	**Yes**	**No**	**Genitourinary:**	**Yes**	**No**
Upper respiratory tract infection	☐	☐	STD	☐	☐
Other_____			Other_____		

Please list your medications and dosages: **None ☐**

_____

_____

Please list any allergies to medications: **None Known ☐** _____

_____

Past History:

Have you had any significant eye injuries in the past?
Yes ☐ No ☐

If yes, please explain: _____

_____

_____

Have you ever had any eye surgery?
Yes ☐ No ☐

If yes, please explain: _____

_____

Additional Notes: _____

Social History: Social Drinker: Yes ☐ No ☐ Smoker: Never Smoker ☐ Current Every day smoker ☐ Current Some Day ☐ Light Tobacco smoker ☐ Former Smoker ☐ Heavy Tobacco Smoker ☐

Hobbies: _____ Occupation _____ Retired ☐ Unemployed ☐

Family History:

Please indicate if anyone in the family (parents, grandparents, siblings) has had any of the following conditions:

Glaucoma Mother ☐ Father ☐ Sister ☐ Brother ☐ Son☐ Daughter ☐
Cataracts Mother ☐ Father ☐ Sister ☐ Brother ☐ Son☐ Daughter ☐
Macular Degeneration Mother ☐ Father ☐ Sister ☐ Brother ☐ Son☐ Daughter ☐
Hypertension Mother ☐ Father ☐ Sister ☐ Brother ☐ Son☐ Daughter ☐
Diabetes Type I Mother ☐ Father ☐ Sister ☐ Brother ☐ Son☐ Daughter ☐
Diabetes Type II Mother ☐ Father ☐ Sister ☐ Brother ☐ Son☐ Daughter ☐
Other _____ Mother ☐ Father ☐ Sister ☐ Brother ☐ Son☐ Daughter ☐

Signature(Must sign each visit) **Date** **Signature** **Date**

_____ _____ _____ _____

Patient Acknowledgement of Fees

There is a $25.00 returned check fee that will be charged to the responsible party if a check has insufficient funds.

Signature of Patient/Responsible Party **Date**

Contact Lens Wearers

Please be advised that Eye Care One charges a contact lens fitting fee once a year to update your contact lens prescription. This fee ranges from $40.00 to $90.00 depending on your prescription. This will be due at the time of service.

Signature of Patient/Responsible Party **Date**

Patients with Medical Coverage Only!!

Due to change of reimbursement policies with local carriers, we have been instructed to charge for refractions. A refraction is the lens prescription that Eye Care One creates for your glasses to ensure the best possible vision. Currently, Medicare does not reimburse for refractions. The charge will be $40.00. This will only be charged, at the most, twice a year, depending on your medical condition. This only applies to those that do not have routine vision coverage.

Signature of Patient/Responsible Party

AUTHORIZATION TO RELEASE INFORMATION/PAYMENT AGREEMENT

I authorize the release of medical information necessary to process insurance claims. A copy of this authorization may be used in place of the original. This authorization may be revoked upon my request in writing. I understand that I am responsible for all professional services and or supplies rendered to either myself or my dependant. I understand that this office will submit my insurance claim for me, as a courtesy, but that it be my responsibility to pay for services rendered. I further understand that if my insurance does not pay for services in full, it is my responsibility to pay for the non-covered, allowable charges within thirty days.

Signature of Patient/Responsible Party **Date**