

PATIENT INFORMATION	INSURANCE
Date _____	Who is responsible for this account? _____
Patient _____	Relationship to Patient _____
Address _____	Insurance Co. _____
City _____ State _____ Zip _____	Group # _____ SS# _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F Age _____ Birthdate _____	Policy holder's DOB _____
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced	Is Patient covered by additional Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No
Patient SS# _____	ASSIGNMENT AND RELEASE
Occupation _____	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.
Employer _____	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.
Employer Phone _____	Responsible Party Signature _____
Spouse's Name _____	Relationship _____ Date _____
Birthdate _____ SS# _____	
Occupation _____	
Spouse's Employer _____	
How did you hear about our clinic? _____	

PHONE NUMBERS

Home _____ Work _____ Ext _____ Mobile _____

Email Address _____ Spouse's Work _____

Best time and place to reach you _____

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

Name _____ Relationship _____

Home Phone _____ Work Phone _____

EYE HEALTH HISTORY	CHIEF COMPLAINT/ HOW CAN WE HELP YOU TODAY?																											
Optometrist _____	<p>In this space please briefly tell us any signs and symptoms you are experiencing.</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>																											
Last Eye Exam _____																												
Ophthalmologist _____																												
Last Visit _____																												
Do you wear glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> All the time <input type="checkbox"/> Occasionally <input type="checkbox"/> Reading <input type="checkbox"/> Driving <input type="checkbox"/> TV	<p style="text-align: center;">HISTORY OF PRESENT ILLNESS (Please Circle One) (1,4)</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%;"><i>Quality</i></td> <td style="width:33%;">Which eye has the problem?</td> <td style="width:33%;">Right Eye, Left Eye, Both Eyes</td> </tr> <tr> <td><i>Context</i></td> <td>Does the problem cause vision loss or blur?</td> <td>Loss Blur</td> </tr> <tr> <td><i>Severity</i></td> <td>Does the problem occur suddenly or gradually?</td> <td>Sudden Gradual</td> </tr> <tr> <td><i>Modifying Factors</i></td> <td>How severe is the problem?</td> <td>Mild Moderate Severe</td> </tr> <tr> <td><i>Duration</i></td> <td>Is it worse at any specific distance?</td> <td>Distance Near Both</td> </tr> <tr> <td><i>Timing</i></td> <td>How long does the problem last?</td> <td>Intermittent Constant</td> </tr> <tr> <td><i>Previous Interventions</i></td> <td>How long has the problem been occurring?</td> <td>Short Term Long Term</td> </tr> <tr> <td><i>Associated Symptoms</i></td> <td>Does anything help the problem?</td> <td>Nothing Helps Nothing Tried</td> </tr> <tr> <td></td> <td>Are there associated symptoms?</td> <td>No Headache Nausea</td> </tr> </table>	<i>Quality</i>	Which eye has the problem?	Right Eye, Left Eye, Both Eyes	<i>Context</i>	Does the problem cause vision loss or blur?	Loss Blur	<i>Severity</i>	Does the problem occur suddenly or gradually?	Sudden Gradual	<i>Modifying Factors</i>	How severe is the problem?	Mild Moderate Severe	<i>Duration</i>	Is it worse at any specific distance?	Distance Near Both	<i>Timing</i>	How long does the problem last?	Intermittent Constant	<i>Previous Interventions</i>	How long has the problem been occurring?	Short Term Long Term	<i>Associated Symptoms</i>	Does anything help the problem?	Nothing Helps Nothing Tried		Are there associated symptoms?	No Headache Nausea
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Do you wear contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____ Hours/Day _____																												
Describe any problems you have with your contacts _____																												

HEALTH HISTORY

Family Practitioner _____ Date of last visit _____

PAST, FAMILY, AND/OR SOCIAL HISTORY

(1,3)

Is there anything in your past history, family history, or social history which would help us care for you?

If Yes, please describe.

- Past History (illness, operations, injuries, medications, treatments) No Yes _____
- Family History (diseases, hereditary, risk factors, glaucoma) No Yes _____
- Social History (past and current activities) No Yes _____

Do you use any of the following products?

- Tobacco No Yes
- Alcohol No Yes
- Recreational Drugs No Yes

Are you pregnant? _____ Number of Children _____

Have you ever been exposed to or infected with:	
Gonorrhea	<input type="checkbox"/> No <input type="checkbox"/> Yes
Hepatitis	<input type="checkbox"/> No <input type="checkbox"/> Yes
HIV	<input type="checkbox"/> No <input type="checkbox"/> Yes
Syphilis	<input type="checkbox"/> No <input type="checkbox"/> Yes

REVIEW OF SYSTEMS- Do you have a problem with...

(1,2,10)

<p>EYES:</p> <p>Blindness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Loss of Vision <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Distorted Vision <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Blurred Vision <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Double Vision <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Crossed Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Flashes or Floaters <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Dry Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Watery Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Red Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Mucous Discharge <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Burning or Itching <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sandy or Gritty Feeling <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Eye Pain or Soreness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Glare/Light Sensitivity <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chronic Eye Infections <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tired Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Halos <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Eye Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Eye Injury <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Retinal Detachment <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Allergic/Immunologic</p> <p>Hay Fever <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Medicine Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Constitutional Symptoms</p> <p>Fever <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Weight Loss <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cardiovascular</p> <p>Heart Pain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Vascular Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Ears,Nose,Mouth,Throat</p> <p>Sinus Problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chronic Cough <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Dry Throat/Mouth <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chronic Ear Infections <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Endocrine</p> <p>Thirsty all the time <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Frequent Urination <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other Glands <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Integumentary</p> <p>Skin <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Genitourinary</p> <p>Genitals <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Kidneys <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Bladder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hematologic/Lymphatic</p> <p>Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Bleeding Problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Swelling <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Musculoskeletal</p> <p>Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rheumatoid Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Muscle Pain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Joint Pain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Neurological</p> <p>Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Migraines <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Psychiatric</p> <p>Nervous Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Compulsive Behavior <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Respiratory</p> <p>Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Shortness of Breath <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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MEDICATIONS

List medications you are currently taking, including eye drops:

Pharmacy Name _____

Phone _____

ALLERGIES

List your allergies to medications or other substances:

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 _____