The Eyecare Place
Personalized Care. Guaranteed Value.

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you.

PATIENT INFORMATION

Date ____________

Patient ______________________________

Address ______________________________

______________________ __________ __________
City State Zip

Sex: ☐ M ☐ F Age________ Birthdate__________

☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Patient SS# ______________________________

Occupation ______________________________

Employer ______________________________

Employer Address ______________________________

Spouse's Name ______________________________

Birthdate __________ SS# ______________

Occupation ______________________________

Spouse's Employer ______________________________

WHOM MAY WE THANK FOR TELLING YOU ABOUT US?

____

PHONE NUMBERS

Home ______________________________

Cell ______________________________

Work ______________________ Ext __________

EMAIL ______________________________

Best time and place to reach you ______________

____

IN CASE OF EMERGENCY, CONTACT

Name ______________________________

Relationship ______________________________

Home Phone ______________________________

Cell Phone ______________________________

Work Phone ______________________________

EYE HEALTH HISTORY

Date of last eye exam______________________

Location______________________________

Do you wear glasses? ☐ Yes ☐ No

☐ Reading ☐ Driving ☐ TV

Do you wear contacts? ☐ Yes ☐ No ☐ Soft ☐ Hard

☐ 1 Day ☐ 2 Week ☐ Monthly ☐ Yearly

☐ All the time ☐ Occasionally

Describe any problems you have with your contacts

____

____

Do you sleep in contact lenses? ☐ Yes ☐ No

Are you interested in:

☐ Glasses
☐ Contact Lenses
☐ Colored Contacts
☐ Sunglasses
☐ Laser Vision Correction

If bifocals were needed I would prefer:

☐ Lined ☐ Invisible

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

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

HEALTH HISTORY

Physician's Name____________________ Date of last visit__________

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

	Yourself	Family Members		Yourself	Family Members
AIDS/HIV	☐ Yes ☐ No	☐ Yes ☐ No	Hepatitis (Type_____)	☐ Yes ☐ No	☐ Yes ☐ No
Allergies	☐ Yes ☐ No	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	☐ Yes ☐ No	Lazy Eye	☐ Yes ☐ No	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	☐ Yes ☐ No	Lupus	☐ Yes ☐ No	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	☐ Yes ☐ No
Bleeding in or around eyes	☐ Yes ☐ No	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	☐ Yes ☐ No
Blindness	☐ Yes ☐ No	☐ Yes ☐ No	Poor Color Vision	☐ Yes ☐ No	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	☐ Yes ☐ No	Retinal Disease	☐ Yes ☐ No	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	☐ Yes ☐ No	Shingles	☐ Yes ☐ No	☐ Yes ☐ No
Diabetes (Type I or Type II)	☐ Yes ☐ No	☐ Yes ☐ No	Skin Conditions	☐ Yes ☐ No	☐ Yes ☐ No
Drug Sensitivity/Allergies	☐ Yes ☐ No	☐ Yes ☐ No	Stroke	☐ Yes ☐ No	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	☐ Yes ☐ No	Thyroid Conditions	☐ Yes ☐ No	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No	☐ Yes ☐ No
Eye Surgery	☐ Yes ☐ No	☐ Yes ☐ No	Turned Eye	☐ Yes ☐ No	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	☐ Yes ☐ No	Tobacco use	☐ Yes ☐ No	
Hay Fever	☐ Yes ☐ No	☐ Yes ☐ No	Alcohol use	☐ Yes ☐ No	
Heart Condition	☐ Yes ☐ No	☐ Yes ☐ No	Are you Pregnant? ☐ Yes ☐ No	Number of Children _________	

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 authorized 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