WELCOME TO OUR PRACTICE

PLEASE PRINT INFORMATION: DATE:_____

Patient's Name_____Age_____

Street Address_____

City_____State_____Zip_____

Home Phone_____Cell Phone_____Sex M or F

Date of Birth_____E-mail_____

Student_____Full-time_____Part-time_____

Patient's Occupation_____SS#_____

Employer_____

Employer's Address_____

City_____State_____Zip_____

Person Responsible for Payment (if patient is a minor – Parent or Guardian)

The policy in our office is the parent who requests treatment for the child is responsible for all fees for services.

Name_____Relationship_____

Address (if different than above)_____

City_____State_____Zip_____

Insurance Information:

Name of Insurance Company_____

Subscriber's Name _____Date of Birth_____

Subscriber's SS# (needed for insurance purposes only)_____

Patient's Relationship to Insured Self_____Spouse_____Child_____Other_____

Subscriber's Employer_____

ID# or Policy #_____Group or Plan #_____

In Case of Emergency, the following person should be notified.

Name_____Relationship_____

Address_____Phone_____

City_____State_____Zip_____

Do you wear glasses (circle) YES NO If yes, how long have you had your current pair?_____

Do you wear contact lenses (circle) YES NO If yes, how long have you had your current pair?_____

What brand of contact lenses do you currently wear?_____

What contact lens solution do you currently use? _____

Are you interested in contact lenses this visit? (there may be additional fees)_____

INSURANCE

INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION (Lifetime Signature)

I hereby authorize and direct payment of my medical/vision benefits to Primary Eye Care Center, P.C. for any services furnished to me by the doctor. I understand that I am financially responsible for payment of any services or supplies that are deemed not medically necessary or non-covered by my insurance company. This includes refractions, contact lens examinations, visual fields, and supplies. It is my responsibility to notify this office of any changes in my insurance plan BEFORE my visit. I further understand that I am responsible for charges incurred when my insurance coverage has been changed or terminated. I also authorize release to my insurance company any information required to process claims of benefits.

MEDICARE PATIENTS: I request that payment of authorized Medicare benefits be made on my behalf to Primary Eye Care Center, P.C. for any services furnished to me by the 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 payable for related services.

_____

Patient Signature (or Responsible Party) Date

MEDICAL HISTORY QUESTIONNAIRE

Do you currently have any problems in the following areas? If "yes" provide additional information.

Constitutional Symptoms:	NO	YES	Explanation of problem:
Fever	____	____	_____
Weight loss	____	____	_____
Fatigue	____	____	_____
Eyes			
Loss of vision	____	____	_____
Blurred vision (halos)	____	____	_____
Loss of side vision	____	____	_____
Double vision	____	____	_____
Dryness	____	____	_____
Mucous discharge	____	____	_____
Redness	____	____	_____
Sandy or gritty feeling	____	____	_____
Itching	____	____	_____
Burning	____	____	_____
Foreign body sensation	____	____	_____
Excess tearing watering	____	____	_____
Occasional tearing	____	____	_____
Glare/light sensitivity	____	____	_____
Eye Pain or soreness	____	____	_____
Chronic infection of eye or lid	____	____	_____
Stye or chalazion	____	____	_____
Fluctuating visual acuity	____	____	_____
Ears, Nose, Mouth, Throat			
Sinus congestion	____	____	_____
Runny nose/post nasal drip	____	____	_____
Chronic cough	____	____	_____
Dry or sore throat/mouth	____	____	_____
Cardiovascular			
Heart failure/heart attack (MI)	____	____	_____
Irregular heartbeat (arrhythmia)	____	____	_____
Other			
Cancer	____	____	_____
Migraine headaches	____	____	_____
Stroke (CVA) or paralysis	____	____	_____
Diabetes	____	____	_____
HIV or AIDS	____	____	_____
Allergy Symptoms	____	____	_____
Sneezing/itching/Rashes	____	____	_____

FAMILY HISTORY	NO	YES	
Blindness	____	____	_____
Cataract	____	____	_____
Glaucoma	____	____	_____
Macular Degeneration	____	____	_____
Retinal Detachment	____	____	_____
Arthritis	____	____	_____
Cancer	____	____	_____
Diabetes	____	____	_____
Heart Disease	____	____	_____
High blood pressure	____	____	_____
Kidney disease	____	____	_____
Lupus	____	____	_____
Stroke	____	____	_____
Thyroid disease	____	____	_____
Tuberculosis	____	____	_____

SOCIAL HISTORY

Do you drive?	____	____	
Difficulty with night vision?	____	____	
Do you drink alcohol?	____	____	Number of drinks per week:_____
Do you smoke?	____	____	Number of packs per day:_____
Have you had a blood transfusion?	____	____	
Are you pregnant/nursing?	____	____	

Have you ever been treated or exposed to an infectious disease: Hepatitis A B C / HIV /AIDS/ Syphilis

List any medications, including eye drops, that you take_____

_____

_____

List any allergies to foods or medications_____

_____

_____

List any surgeries, injuries, or major illnesses_____

_____

_____