Comprehensive Eyecare & Disease

PREMIER EYECARE & OPTICAL

WELCOME TO OUR OFFICE

PATIENT INFORMATION

Today's Date: _____

Name: _____ Date of Birth: _____
Last First MI

Street: _____ Social Security #: _____
(Per insurance requirement only)

City: _____State: ____ Zip: _____ Age: _____ Sex: □ M □ F

Home Phone: _____ Marital Status: □ Single □ Mar □ Div □ Wid □ Sep

Cell Phone: _____ Is texting okay? □ Yes □ No

E-mail: _____ May we correspond with you by e-mail? □ Yes □ No

Work Phone: _____ Date of Last Exam: _____

What is the major purpose of this visit? _____

Are you interested in: Glasses Contacts Both (circle one)

Employer (or School): _____ Spouse (or Parent's Name): _____

Occupation (or Grade): _____ Spouse (or Parent's Work Phone): _____

INSURANCE INFORMATION

(Please provide your insurance cards to the receptionist)

Primary Insurance Carrier: _____ **Vision Insurance Carrier:** _____

Member ID #:_____ Group #: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Policy Holder's SS#: _____ Patient's relationship to the policy holder:

□ Self □ Spouse □ Child □ Other

Secondary Insurance Carrier (if applicable): _____

Member ID #:_____ Group #: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Policy Holder's SS#: _____ Patient's relationship to the policy holder:

□ Self □ Spouse □ Child □ Other

How will you settle your account today?

□ Check □ Cash □ Credit Card □ Flex Spending Account □ Care Credit

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I acknowledge that I will be responsible for the payment of all charges for professional services and/or goods received regardless of whether or not I have insurance coverage. I also authorize Premier Eyecare & Optical or insurance company to release any information required to process my claims.

I acknowledge that all co-pays and fees are expected at the time of the visit. Premier Eyecare & Optical is not responsible for out-of-network costs or balances due after insurance has been billed. Any remaining account balance will be billed to the patient.

_____ _____

Patient/Guardian Signature Date

MEDICAL HISTORY

Current Medications (RX or Over the counter)		**Name of medications**
Antihistamines	□ Yes □ No	
Diuretics (Water Pills)	□ Yes □ No	
Blood Pressure Pills	□ Yes □ No	
Oral Contraceptives	□ Yes □ No	
Sleeping Tablets	□ Yes □ No	
Eye Drops	□ Yes □ No	
Other	□ Yes □ No	

Do you have any allergies, medication or other? If yes, please explain: _____

_____

_____

Your Eye Health History		**Family Health History**		**Relationship**
Blindness	□ Yes □ No	Blindness	□ Yes □ No	
Cataracts	□ Yes □ No	Cataracts	□ Yes □ No	
Glaucoma	□ Yes □ No	Glaucoma	□ Yes □ No	
Macular Degeneration	□ Yes □ No	Macular Degeneration	□ Yes □ No	
Diabetes	□ Yes □ No	Diabetes	□ Yes □ No	
Lazy Eye	□ Yes □ No	Heart Disease	□ Yes □ No	

Your General Health: Have you ever had or do you currently have……. Check if applies

Eyes
□ Loss of Vision □ Blurred Vision
□ Distorted Vision/Halos □ Double Vision
□ Dryness □ Sandy or Gritty Feeling
□ Mucous Discharge
□ Redness
□ Itching □ Burning
□ Foreign Body Sensation
□ Excess Tearing/Watering
□ Glare/Light
□ Eye Pain or Soreness
□ Chronic Infection of Eye Or Lid
□ Sties or Chalazion
□ Tired Eyes

Gastrointestinal
□ Diarrhea
□ Constipation

Ears, Nose, Mouth, Throat
□ Allergies, Hay Fever
□ Sinus Congestion
□ Runny Nose
□ Post Nasal Drip
□ Chronic Cough
□ Dry Throat/Mouth

Respiratory
□ Asthma
□ Chronic Bronchitis
□ Emphysema

Vascular/Cardiovascular
□ Diabetes
□ Heart Pain
□ High Blood Pressure
□ Vascular Disease

Lymphatic/Hematologic
□ Anemia
□ Bleeding Problems
□ **Allergic/Immunologic**
□ **Psychiatric**

Endocrine
□ Thyroid/Other Glands

Bones/Joints/Muscles
□ Rheumatoid Arthritis
□ Muscle Pain
□ Joint Pain

Constitutional
□ Fever, Weight Loss/Gain

Neurological
□ Headaches
□ Migraines
□ Seizures/Epilepsy

Additional Social History This information is kept strictly confidential
□ I would prefer to discuss my Social History information directly with my doctor. (Check box)
Do you drive? □ Yes □ No If Yes, do you have visual difficulty when driving? □ Yes □ No
If Yes, please describe: _____
Have you ever been exposed to/infected with: □ Gonorrhea □ Hepatitis □ HIV □ Syphilis
Are you pregnant? □ Yes □ No. If Yes, how many months? _____
Are you currently breastfeeding? □ Yes □ No

_____ _____
Patient/Guardian Signature *Date*