EYECARE REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date_____

Patient_____

Address_____

_____
City State Zip

Sex: ☐ M ☐ F Age_____ Birthdate_____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS#_____

Occupation_____

Employer_____

Employer Address_____

Employer Phone_____

Spouse's Name_____

Birthdate_____ SS#_____

Occupation_____

Spouse's Employer_____

Whom may we thank for referring you?_____

_____

2 INSURANCE

Who is responsible for this account?_____

Relationship to Patient_____

Insurance Co._____

Group #_____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name_____

Birthdate_____ SS#_____

Relationship to Patient_____

Insurance Co._____

Group #_____

ASSIGNMENT AND RELEASE

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. 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.

_____
Responsible Party Signature

_____ _____
Relationship Date

3 PHONE NUMBERS

Home_____ Work_____ Ext_____ 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_____

4 EYE HEALTH HISTORY

Date of last eye exam?_____

Name of eye doctor_____

Do you wear glasses? ☐ Yes ☐ No

☐ All the time ☐ Occasionally

☐ Reading ☐ Driving ☐ TV

Do you wear contacts? ☐ Yes ☐ No

Type_____ Hours/Day_____

Describe any problems you have with your contacts and or eyes_____

_____

_____

_____

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

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

– OVER –

5 HEALTH HISTORY

Primary Care Physician's Name_____ Phone_____ 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	
AIDS/HIV	☐ Yes	☐ No	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	☐ Yes	☐ No
Bleeding	☐ Yes	☐ No	☐ Yes	☐ No
Blindness	☐ Yes	☐ No	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	☐ Yes	☐ No
Cholesterol (High)	☐ Yes	☐ No	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	☐ Yes	☐ No
Drug Sensitivity	☐ Yes	☐ No	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	☐ Yes	☐ No
Eye Surgery	☐ Yes	☐ No	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No	☐ Yes	☐ No
Heart Condition	☐ Yes	☐ No	☐ Yes	☐ No
Hepatitis (Type_____)	☐ Yes	☐ No	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No	☐ Yes	☐ No
Lazy Eye	☐ Yes	☐ No	☐ Yes	☐ No
Lupus	☐ Yes	☐ No	☐ Yes	☐ No
Migraine Headaches	☐ Yes	☐ No	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No	☐ Yes	☐ No
Poor Color Vision	☐ Yes	☐ No	☐ Yes	☐ No
Retinal Disease	☐ Yes	☐ No	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	☐ Yes	☐ No
Shingles	☐ Yes	☐ No	☐ Yes	☐ No
Skin Conditions	☐ Yes	☐ No	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	☐ Yes	☐ No
Thyroid Conditions	☐ Yes	☐ No	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	☐ Yes	☐ No
Turned Eye	☐ Yes	☐ No	☐ Yes	☐ No

Are you pregnant?_____ Number of children_____

Tobacco use_____ Alcohol use_____

MEDICATIONS

List medications you are currently taking, including eye drops:

_____

_____

_____

_____

Pharmacy Name_____

Phone_____

ALLERGIES

List your allergies to medications or other substances:

_____

_____

_____

_____

_____

_____

6 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