

Patient Eye History

PLEASE COMPLETE BOTH SIDES OF FORM

Patient Name: _____ Today's Date: _____
Last First Middle

Address: _____
Street City State Zip

Phone: (_____) _____ Alternate Phone: (_____) _____ Age: _____ Sex Male Female

Social Security Number: _____ Date of Birth: _____

Email: _____
For office use only.

In order to submit a claim to your insurance company for services that you are eligible for, we must obtain a copy of your insurance card. This information is used to submit a claim for payment and must be provided on the date that services are rendered. In the event that your insurance company deems the information that you have provided us to be incorrect, you will be responsible for payment of the rendered services.

Name of Insurance Policy Holder or Responsible Party: Relationship to Patient _____

Last _____ First _____ MI _____

Birth Date _____ SSN# _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Employer _____ Work Phone _____

Primary Medical Insurance Or Medicare Plan:

Name of Insurance _____

Group # _____

ID # _____

Primary Vision Insurance:

Name of Insurance _____

Group # _____

ID# _____

Secondary Medical Insurance Or Medicare Plan:

Name of Insurance _____

Group # _____

ID # _____

Secondary Vision Insurance:

Name of Insurance _____

Group # _____

ID# _____

Please copy the patient's insurance card(s).

Many eye diseases begin in your side, or peripheral, vision. A standard eye examination tests your central vision, which comprises only about 15% of your visual field. As such, a routine exam may not detect diseases early enough to prevent permanent vision loss. A visual field test evaluates the remaining 85% and may alert us to the presence of potentially vision threatening diseases, such as Glaucoma, tumors, neurological diseases, and retinal detachment. This test can also detect certain systemic diseases such as hypertension, lupus and diabetes, all of which can also lead to vision loss.

There is an additional fee for this test. YES, I DO want the visual field test

The HIPAA Policy was available to read during my office visit. _____ (Patient Initials)

Our office will file all vision claims if we are a participating provider for your plan. However, if your insurance denies payment for any claims submitted, you will be responsible for full payment. Otherwise, we will supply you with an itemized statement which you may submit to your insurance carrier. Full payment is required at the time of service.

Please check your method of payment. Cash Check Credit Card

I have read and understand the Statement of Financial Responsibility.

Signature of Patient (or Guardian) _____ **Date** _____

Signature of Physician _____ **Date** _____

Patient Medical Information

PLEASE COMPLETE BOTH SIDES OF FORM

Many medical conditions and medications affect the eyes. Please help the doctor by filling out your medical history as completely as possible. Please check all of the conditions that apply to you:

Have you had any eye injuries, eye surgeries, eye diseases, floaters or flashes of light? _____

Breathing Problem ___ Asthma ___ Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Disorder ___ Sickle Cell ___ High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Musculoskeletal Conditions ___ Arthritis ___ Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Skin Condition ___ Eczema ___ Rosacea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Allergy/Immunology ___ Hayfever ___ HIV ___ Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ears/Nose/Throat Problems ___ Sinus Problems ___ Dental Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Endocrine Disorder ___ Diabetes ___ Thyroid Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney/Bladder Problem Surgical Operations	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neurological Disorder ___ Migraine Headaches ___ Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stomach Problem ___ Heartburn	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fever/Fatigue/Weight Loss Cancer__	<input type="checkbox"/> Yes <input type="checkbox"/> No	___ Myasthenia Gravis ___ Head Injury ___ Stroke	
Heart Problem ___ High Blood Pressure ___ Heart Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Disorder ___ Anxiety ___ Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Are you currently being treated for any other medical conditions? Yes No

If yes, what? _____

Date of last general health exam: _____ Date of last eye exam: _____ Previous eye care provider: _____

Please list any medications you are now taking

(including hormones, birth control, aspirin or other anti-inflammatories, and eye drops):

Is there any possibility you might be pregnant? Yes No N/A

Do you smoke or use tobacco? Yes No

Do you drink alcohol? Yes No

Are you allergic to any medications? Yes No If yes, please list: _____

Family History

Has anyone in your family had: Please check all that apply and indicate their relation to you.

<input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Cataract _____
<input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Glaucoma _____
<input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Macular Degeneration _____
<input type="checkbox"/> Yes <input type="checkbox"/> No Respiratory Disease _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Blindness _____
<input type="checkbox"/> Yes <input type="checkbox"/> No Cancer _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Other Eye Disease _____