Drs Eyecare
FAMILY VISION

PATIENT INFORMATION FORM

PLEASE PRINT CLEARLY Today's Date _____
Last Name _____First Name_____M.I._____
Title: Dr./ Mr./ Mrs./ Ms./ Rev. Nickname:_____
Address: _____
City: _____State:_____Zip_____
Home Phone (_____)_____Daytime Phone (_____)_____
Cell Phone (_____)_____Email_____
Primary influence for selecting our practice:

_____Referred by _____
_____Insurance Panel List
_____Internet/Website
_____Walk-In
_____Other _____

Gender: M F Date of Birth_____Age_____
Social Security Number _____
Marital Status: Married/ Divorced/ Single/ Widow(er)/ Domestic Partner
Employer or School: _____
Occupation:_____
Preferred Language: _____Race: _____

Primary Insurance to File
Policy # _____Group #_____
Insured's Name_____Member's DOB_____Relationship to patient _____
Insured's SS# _____ID#_____
Insurance Company Name _____Phone #_____
Insurance Company Address_____

Secondary Insurance to File
Policy # _____Group #_____
Insured's Name_____Member's DOB_____Relationship to patient _____
Insured's SS# _____ID#_____
Insurance Company Name _____Phone #_____
Insurance Company Address_____

Guarantor Information (Who will be responsible for this account?)
_____Check here if same as above or

Name_____Relationship to patient_____
Address_____City, State, Zip _____
Home phone # (_____)_____Cell Phone# (_____)_____

All patients please read and sign below
I authorize Drs Eyecare to release any medical information to my insurance company (or companies) and to accept assignment of benefits. I understand that I may have co-payments and overages (costs not paid for by the eye care and/or medical plan), and I am ultimately responsible for all fees incurred.

Patient or Responsible Party's Signature _____Date_____

Notice of Privacy Practices Acknowledgment

I acknowledge that I received a copy of Drs Eyecare's Notice of Privacy Practices.

Patient Name_____Date_____

Signature_____

MEDICAL HISTORY

PLEASE PRINT CLEARLY Today's Date _____

Last Name_____First Name_____M.I._____

Purpose of your visit_____

_____Date of last eye exam_____

Date of last physical exam_____by Dr. _____

Are you allergic to _____Penicillin_____Sulfa_____Codeine _____Other

Please list all medications you take (including oral contraceptives, aspirin, over-the-counter medications, vitamins and supplements)_____

_____

_____

List any eye surgeries _____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, glaucoma, retinal disease, cataracts, eye infections or eye injuries: _____

_____

Are you pregnant and/or nursing? _____no _____yes

Do you wear glasses? _____no _____yes If yes, how old are your present glasses? _____

Do you wear contact lenses? _____no _____yes

If yes, how old are your current lenses?_____

Type of contact lenses _____Rigid_____Soft_____Extended Wear _____other

Are they comfortable? _____yes_____no

FAMILY MEDICAL HISTORY

Please list the family member(s) with the following eye or medical conditions:

Disease/Condition		**Family member (IE mother, father, paternal grandfather, etc)**
1. Blindness	Y/ N	_____
2. Crossed eyes	Y/ N	_____
3. Cataract	Y/ N	_____
4. Glaucoma	Y/ N	_____
5. Macular Degeneration	Y/ N	_____
6. Retinal Disease/Detachment	Y/ N	_____
7. Arthritis	Y/ N	_____
8. Diabetes	Y/ N	_____
9. Hypertension	Y/ N	_____
10. Heart Disease	Y/ N	_____
11. Thyroid Disease	Y/ N	_____
12. Other		_____

SOCIIAL HISTORY

Do you currently drive? _____yes _____no Do you have visual difficulties when driving? _____no _____yes If yes, please describe _____

Do you use tobacco products? _____no _____yes

If yes, type/amount/how long?_____

REVIEW OF SYSTEMS: Do you have any health problems related to the following. Please circle. If yes, please explain.

System	Yes or No	Not Sure	Explain/Medications
I. Skin	Y/ N	?	_____
II. Neurologic			
1. Headaches/Migraines	Y / N	?	_ _____
2. Seizures	Y/ N	?	_____
III. Eyes			
1. Loss of Vision	Y/ N	?	_____
2. Double Vision	Y/ N	?	_____
3. "Pink "/Red eye	Y/ N	?	_____
4. Light Sensitive	Y/ N	?	_____
5. Eye Pain	Y/ N	?	_____
6. Eye Infections	Y/ N	?	_____
7. Watery Eyes	Y/ N	?	_____
8. Dry Eyes	Y/ N	?	_____
IV. Ears, Nose, Mouth, Throat			
1. Allergies	Y/ N	?	_____
2. Hay Fever	Y/ N	?	_____
3. Sinus Congestion	Y/ N	?	_____
4. Runny Nose	Y/ N	?	_____
5. Dry Throat/Mouth	Y/ N	?	_____
6. Ear Infections	Y/ N	?	_____
V. Respiratory			
1. Asthma	Y/ N	?	_____
2. Chronic Bronchitis	Y/ N	?	_____
3. Emphysema	Y/ N	?	_____
VI. Vascular			
1. Diabetes	Y/ N	?	_____
2. High Blood Pressure	Y/ N	?	_____
3. Vascular Disease	Y/ N	?	_____
VII. Gastrointestinal			
1. Diarrhea	Y/ N	?	_____
2. Constipation	Y/ N	?	_____
VIII. Genitourinary			
1. Genitals	Y/ N	?	_____
2. Kidney/Bladder	Y/ N	?	_____
IX. Bones/ Joints/ Muscles			
1. Rheumatoid Arthritis	Y/ N	?	_____
2. Muscle/ Joint Pain	Y/ N	?	_____
X. Lymphatic/Hematological			
1. Anemia	Y/ N	?	_____
2. Bleeding Problems	Y/ N	?	_____
XI. Endocrine			
1. Thyroid/ Other	Y/ N	?	_____
XII. Psychiatric			
1. Anxiety	Y/ N	?	_____
2. Depression	Y/ N	?	_____
XIII. Constitutional			
1. Fever	Y/ N	?	_____