Drs Eyecare
FAMILY VISION

PATIENT INFORMATION FORM

PLEASE PRINT CLEARLY

Last Name: _____ First Name: _____ M.I._____
Title: Dr./ Mr./ Mrs./ Ms./ Rev. Nickname: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home phone: (_____) _____ Work phone: (_____)_____
Cell phone: (_____) _____ Email: _____

Primary influence for selecting our practice:

_____ Referred by: _____
_____ Insurance Panel List
_____ Internet/ Website
_____ Walk-In
_____ Other: _____

Gender: Male/ Female 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 SSN: _____
Insurance company's name _____
Insurance company's phone number: _____
Insurance company's address: _____
City: _____ State: _____ Zip Code: _____

Secondary insurance to file

Policy #: _____ Group #: _____
Insured's name: _____ Member's DOB: _____
Relationship to patient: _____ Insured's SSN: _____
Insurance company's name _____
Insurance company's phone number: _____
Insurance company's address: _____
City: _____ State: _____ Zip Code: _____

Guarantor information (who will be responsible for this account?)
_____ Check here if same as above

If the guarantor information is different please fill in information below

Name: _____ Relationship to Patient: _____
Address: _____
City: _____ State: _____ Zip Code: _____
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: _____
Purpose of your visit _____
_____ Date of last eye exam _____
Date of last physical exam _____ Primary Care Physician _____
Phone number for Primary Care Physician _____
Are you allergic to any of the following? Penicillin _____ Sulfa _____
Codeine _____ Latex _____ Other _____
Please list all medications you are currently taking (including oral contraceptives, aspirin, over-the-counter medications, vitamins and supplements) _____
_____
_____
_____
List any eye surgeries _____
Circle/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? yes _____ no _____
Do you wear glasses? yes _____ no _____ If yes, how old are your current glasses? _____
Do you wear contact lenses? yes _____ no _____ Are your contacts comfortable? _____

If yes, how old are your current contacts? _____
If yes, what's the brand of contacts you wear? _____
If yes, are your contacts – Rigid ____ Soft _____ Extended Wear _____

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

Disease/ Conditions		Family member (ie mother, father, brother, sister)
1. Cancer	yes/no	_____
2. Diabetes	yes/no	_____
3. Hypertension	yes/no	_____
4.Thyroid	yes/no	_____
5. Cataract	yes/no	_____
6. Macular Degeneration	yes/no	_____
7. Glaucoma	yes/no	_____
8. Other	yes/no	_____

SOCIAL HISTORY
Do you currently drive? yes _____ no _____ Do you have visual difficulties when driving? yes ___ no___ If yes, please describe _____
Do you use tobacco products? yes ____ no ____
If yes, please list the brand, amount per day, and how long have you been smoking?
_____

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

SYSTEM		**EXPLAIN/ MEDICATIONS**
Constitution		
Cancer	**Yes / No**	_____
Other	**Yes / No**	_____
Ear,Nose and Throat		
Hearing Loss	**Yes / No**	_____
Sinusitis	**Yes / No**	_____
Dry Mouth	**Yes / No**	_____
Other	**Yes / No**	_____
Neurological		
Multiple Sclerosis	**Yes / No**	_____
Epilepsy	**Yes / No**	_____
Stroke/CVS	**Yes / No**	_____
Migraine	**Yes / No**	_____
Other	**Yes / No**	_____
Psychiatric		
Depression	**Yes / No**	_____
Attention Deficit	**Yes / No**	_____
Anxiety Disorder	**Yes / No**	_____
Other	**Yes / No**	_____

Cardiovascular

Hypertension	**Yes / No**	_____
Heart Disease	**Yes / No**	_____
Vascular Disease	**Yes / No**	_____
Other	**Yes / No**	_____

Respiratory

Asthma	**Yes / No**	_____
Bronchitis	**Yes / No**	_____
Emphysema	**Yes / No**	_____
COPD	**Yes / No**	_____
Sleep Apnea	**Yes / No**	_____
Other	**Yes / No**	_____

Gastrointestinal

Crohns	**Yes / No**	_____
Colitis	**Yes / No**	_____
Ulcer	**Yes / No**	_____
Acid Reflux	**Yes / No**	_____
Other	**Yes / No**	_____

Genitourinary

Kidney Disease	**Yes / No**	_____
Other	**Yes / No**	_____

Muscular/Skeletal

Arthritis	**Yes / No**	_____
Osteoarthritis	**Yes / No**	_____
Fibromyalgia	**Yes / No**	_____
Gout	**Yes / No**	_____
Other	**Yes / No**	_____

Integumentary/Skin

Eczema	**Yes / No**	_____
Rosacea	**Yes / No**	_____
Psoriasis	**Yes / No**	_____
Other	**Yes / No**	_____

Endocrine

Type 2 Diabetes	**Yes / No**	_____
Type 1 Diabetes	**Yes / No**	_____
Thyroid Dysfunction	**Yes / No**	_____
Hormonal Dysfunction	**Yes / No**	_____
Other	**Yes / No**	_____

Hemotologic/Lymphatic

Anemia	**Yes / No**	_____
Hypercholesterolemia	**Yes / No**	_____
Other	**Yes / No**	_____

Allergic/Autoimmune

Environmental Allergies	**Yes / No**	_____
Rheumatoid Arthritis	**Yes / No**	_____
Lupus	**Yes / No**	_____
Sjogrens Syndrome	**Yes / No**	_____
Other	**Yes / No**	_____