PRIME EYE CARE

Patient Name: ____ DOB_______________________
SSN # __________________________ Sex _____M_____F Marital Status _____M_____S_____W
Address:__________________________________ City:________________ State: _________Zip:________
Phone: Home _____________________Office____________________E-mail________________________
Primary Care Physician ____________________________ ____Phone Number_______________________
Last Eye Doctor__________________________________ Last Eye Exam ____________________________

Primary Insurance:

Medical__________________________ Member ID# _________________ Group#___________________
Vision ___________________________ Member ID# _________________ Group#___________________

Secondary Insurance:

Medical__________________________ Member ID#__________________ Group#___________________

Policy Holder:

Name:________________________________DOB:________________SSN#_________________________

<u>Ocular History</u> Please circle any disease or surgeries that you have been treated for in the past.

Cataracts Macular Degeneration Glaucoma Retinal Detachment Iritis/Uveitis

Ocular Surgeries: Cataracts / Retinal / Glaucoma / Muscle / Lid / Cornea / Refractive

Ocular Medications: ____

Ocular Injuries: ____

<u>Family History</u> Please circle any health problems that any immediate family member has.

Diabetes / High Blood Pressure / Heart / Lung / Stroke / Cancer / Glaucoma / Macular Degeneration

<u>Social History</u>

Do you smoke or chew tobacco? YES / NO How many cigarettes per day? ____________

Do you drink alcohol? YES / NO How much per day? _____________________

Do you use any illicit drugs? YES / NO

<u>Medications</u> **Please list ALL medications you are presently taking**

Are you allergic to any medications? Please list

How did you find out about our office?

Insurance / Friend or Family / Expo / Doctor Referral / Advertisement / Previous Patient

Occupation ____

Authorized Individual to discuss your eye health with: ____

PLEASE COMPLETE THE BACK SIDE OF THIS FORM

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Medical History

Do you currently, or have you ever had any problems in the following areas:

	YES
CONSTITUTIONAL	
Fever, Weight Loss / Gain	___
CARDIOVASCULAR	
Hypertension	___
Heart Attack (MI)	___
Cholesterol	___
Congestive Heart Failure	___
Coronary Artery Disease	___
Aneurysms	___
Arrhythmias	___
GASTROINTESTINAL	
Ulcers	___
Bowel Disorders	___
Reflux Disease	___
Diverticulitis	___
Colon Cancer	___
INTEGUMENTARY	
Skin Cancer	___
Psoriasis	___
Rosacea	___
NEUROLOGICAL	
Multiple Sclerosis	___
Alzheimer’s	___
Stroke	___
Parkinson’s	___
Headaches	___
Muscular Dystrophy	___
IMMUNOLOGY	
HIV	___
AIDS	___
PHYCHIATRIC	
Depression	___
Drug Dependence	___
Eating Disorder	___
Alcoholism	___
Schizophrenia	___
Panic Disorder	___

	YES
EAR / NOSE / THROAT	
Sinusitis	___
Ear Infection	___
Allergies	___
RESPIRATORY	
Emphysema	___
Bronchitis	___
Asthma	___
COPD	
Lung Cancer	___
Pneumonia	___
MUSCULOSKELETAL	
Arthritis	___
Osteoporosis	___
Gout	___
TMJ	___
ENDOCORINE	
Diabetes	___
Thyroid	___
Pituitary	___
HEMATOLOGIC / LYMPHATIC	
Anemia	___
Leukemia	___
Lymphoma	___
Breast Cancer	___
GENITOURINARY	___
Renal Failure	___
Urinary Tract Infection	___
Sexually Transmitted Disease	___
Nephritis	___
Prostate Cancer	___
Ovarian Cancer	
OTHER PLEASE LIST	

I authorize and request that payments under my insurance plan be made directly to Prime Eye Care for the services furnished to me. I also authorize Prime Eye Care to release information needed for treatment, payment of claims and healthcare operations. I further permit copies of this authorization to be used in place of the original. I do realize that there will be a portion of the bill that is my responsibility and do agree to pay that portion. I understand and agree, should my account be turned over to a collection agency, I will be responsible for collection fees of 50% of the outstanding balance. I also understand and agree that should a suit be brought against me I will pay court costs and attorney fees.

Patient Signature:____ **Date**:________________________