

Prime Eye Care

Patient Name _____ SSN # _____

DOB / / Sex ___ M ___ F Marital Status ___ M ___ S ___ W

Address _____ City _____ State ___ Zip _____

Phone: Home _____ Office _____ E-mail _____

Primary Care Physician _____ Last Eye Doctor _____

Insurance: Medical _____ Vision _____

Emergency contact: _____ Phone: _____

Ocular History

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: Cataract / Retinal / Glaucoma / Muscle / Lid / Refractive / Cornea

Ocular medications: _____

Ocular injuries: _____

Family History

Please circle any of the health problems that any immediate family member has.

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

Social History

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

Medications: (Please list all medications you are presently taking)

Please list any medications that have caused *adverse or allergic reactions*.

How did you find out about our office?

Insurance / Family-Friend / Advertisement / Doctor Referral / Phone book / Previous patient

Occupation: _____ / Retired / Student

Authorized individuals to discuss your eye health with: _____

PLEASE COMPLETE THE BACKSIDE OF THIS FORM

Medical History

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

	<u>YES</u>		<u>YES</u>
CONSTITUTIONAL		EARS / NOSE / THROAT	
Fever, Weight Loss / Gain	_____	Sinusitis	_____
CARDIOVASCULAR		Ear Infection	_____
Hypertension	_____	Allergies	_____
Heart Attack (MI)	_____	RESPIRATORY	
Cholesterol	_____	Emphysema	_____
Congestive Heart Failure	_____	Bronchitis	_____
Coronary Artery Disease	_____	Asthma	_____
Aneurysms	_____	COPD	
Arrhythmias	_____	Lung Cancer	_____
GASTROINTESTINAL		Pneumonia	_____
Ulcers	_____	MUSCULOSKELETAL	
Bowel Disorders	_____	Arthritis	_____
Reflux Disease	_____	Osteoporosis	_____
Diverticulitis	_____	Gout	_____
Cancer	_____	TMJ	_____
INTEGUMENTARY		ENDOCRINE	
Skin Cancer	_____	Diabetes	_____
Psoriasis	_____	Thyroid	_____
Rosacea	_____	Pituitary	_____
NEUROLOGICAL		HEMATOLOGIC / LYMPHATIC	
Multiple Sclerosis	_____	Anemia	_____
Alzheimer's	_____	Leukemia	_____
Stroke	_____	Lymphoma	_____
Parkinson's	_____	GENITOURINARY	
Headaches	_____	Renal Failure	_____
Muscular Dystrophy	_____	Urinary Tract Infection	_____
IMMUNOLOGY		Sexually Transmitted Disease	_____
HIV	_____	Nephritis	_____
AIDS	_____	Prostate Cancer	_____
PSYCHIATRIC		Ovarian Cancer	_____
Depression	_____	OTHER	
Drug Dependence	_____		
Eating Disorder	_____		
Alcoholism	_____		
Schizophrenia	_____		
Panic Disorder	_____		

I authorize and request that payments under my insurance program 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 up to 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: _____