PRIME EYE CARE

Patient Name: _____ DOB_____
SSN # _____ Sex _____M_____F Marital Status _____M_____S_____W
Address:_____ City:_____ State: _____Zip:_____
Phone: Home _____ Cell _____ Can we text you? Yes ____ No ____
Email Address: _____
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#_____

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

Ocular Medications: _____

Ocular Injuries: _____

Family History Please circle any 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**

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		YES
CONSTITUTIONAL		**EAR / NOSE / THROAT**	
Fever, Weight Loss / Gain	___	Tinnitus	___
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	___
Colon Cancer	___	TMJ	___
INTEGUMENTARY		**ENDOCORINE**	
Skin Cancer	___	Diabetes	___
Psoriasis	___	Thyroid	___
Rosacea	___	Pituitary	___
NEUROLOGICAL		**HEMATOLOGIC / LYMPHATIC**	
Multiple Sclerosis	___	Anemia	___
Alzheimer's	___	Leukemia	___
Stroke	___	Lymphoma	___
Parkinson's	___	Breast Cancer	___
Headaches	___	**GENITOURINARY**	___
Muscular Dystrophy	___	Renal Failure	___
IMMUNOLOGY		Urinary Tract Infection	___
HIV	___	Sexually Transmitted Disease	___
AIDS	___	Nephritis	___
PHYCHIATRIC		Prostate Cancer	___
Depression	___	Ovarian Cancer	
Drug Dependence	___	**OTHER PLEASE LIST**	
Eating Disorder	___		
Alcoholism	___		
Schizophrenia	___		
Panic Disorder	___		

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**: _____