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#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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**

**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 \_\_\_ 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 \_\_\_

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**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_