EYECARE REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____ SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Home (____) _____ Cell (____) _____ Spouse's Work Phone (____) _____ Ext _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home (____) _____ Cell (____) _____ Work Phone (____) _____ Ext _____

4 EYE HEALTH HISTORY

Physician's Name _____

Date of last visit _____

Date of last eye exam _____

Name of doctor _____

Do you wear glasses? ☐ Yes ☐ No

☐ All the time ☐ Occasionally
☐ Reading ☐ Driving ☐ TV

Do you wear contacts? ☐ Yes ☐ No

Type _____ Hours/Day _____

Describe any problems you have with your contacts _____

_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Bloodshot Eyes	☐ Yes ☐ No		Floaters or Spots	☐ Yes ☐ No	
Blurred Vision – Distance	☐ Yes ☐ No		Glaucoma	☐ Yes ☐ No	
Blurred Vision – Near	☐ Yes ☐ No		Headaches	☐ Yes ☐ No	
Burning Eyes	☐ Yes ☐ No		Itching Eyes	☐ Yes ☐ No	
Cataracts	☐ Yes ☐ No		Light Sensitive	☐ Yes ☐ No	
Color Vision, Poor	☐ Yes ☐ No		Loss of Vision	☐ Yes ☐ No	
Crossed Eyes	☐ Yes ☐ No		Migraine Headaches	☐ Yes ☐ No	
Discharge from Eyes	☐ Yes ☐ No		Night Vision, Poor	☐ Yes ☐ No	
Dizzy Spells	☐ Yes ☐ No		Red Eyes	☐ Yes ☐ No	
Double Vision	☐ Yes ☐ No		Seeing Halos	☐ Yes ☐ No	
Dry Eyes	☐ Yes ☐ No		Seeing Flashes	☐ Yes ☐ No	
Eye Infection	☐ Yes ☐ No		Temporary Loss of Vision	☐ Yes ☐ No	
Eye Injury	☐ Yes ☐ No		Twitching Eyelid	☐ Yes ☐ No	
Eye Strain	☐ Yes ☐ No		Vision Poor	☐ Yes ☐ No	
Fainting Spells, Blackouts	☐ Yes ☐ No		Watering Eyes	☐ Yes ☐ No	

5 HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following. Also place a mark to indicate if a blood relative has had any of the following problems.

	Yourself	Family Members		Yourself	Family Members
AIDS/HIV	☐ Yes ☐ No	☐ Yes ☐ No	Hepatitis (Type_____)	☐ Yes ☐ No	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	☐ Yes ☐ No	Lazy Eye	☐ Yes ☐ No	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	☐ Yes ☐ No	Lupus	☐ Yes ☐ No	☐ Yes ☐ No
Bleeding	☐ Yes ☐ No	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	☐ Yes ☐ No
Blindness	☐ Yes ☐ No	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	☐ Yes ☐ No	Poor Color Vision	☐ Yes ☐ No	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	☐ Yes ☐ No	Retinal Disease	☐ Yes ☐ No	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	☐ Yes ☐ No	Shingles	☐ Yes ☐ No	☐ Yes ☐ No
Drug Sensitivity	☐ Yes ☐ No	☐ Yes ☐ No	Skin Conditions	☐ Yes ☐ No	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	☐ Yes ☐ No	Stroke	☐ Yes ☐ No	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	☐ Yes ☐ No	Thyroid Conditions	☐ Yes ☐ No	☐ Yes ☐ No
Eye Surgery	☐ Yes ☐ No	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	☐ Yes ☐ No	Turned Eye	☐ Yes ☐ No	☐ Yes ☐ No
Hay Fever	☐ Yes ☐ No	☐ Yes ☐ No	Are you pregnant? _____	Number of children_____	
Heart Condition	☐ Yes ☐ No	☐ Yes ☐ No	Tobacco use_____	Alcohol use_____	

MEDICATIONS

List any medications you are currently taking, including eye drops:

_____

_____

Pharmacy Name_____

Phone (_____) _____

ALLERGIES

List your allergies to medications or other substances:

_____

_____

_____

_____

6 MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to

_____ for any services furnished to me by that provider.
Name of Doctor or Clinic

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____ _____
Signature of Beneficiary, Guardian or Personal Representative Date

_____ _____
Please print name of Beneficiary, Guardian or Personal Representative Relationship to Beneficiary