Patient Information

○ Dr. ○ Mr. ○ Ms. ○ Mrs. ○ Miss ○ Male ○ Female ○ Single ○ Married ○ Widowed ○ Partner

Name *(Last , First, M.I.)* | Nickname

Address | City | State | Zip Code + 4 Digits

Primary Phone H W C | Secondary Phone H W C | Email

Date of Birth | Age | Social Security Number (SS#) | Race

Occupation/Title | Employer | Employer Phone #

Employer Address *(Street, City, State, Zip)*

Spouse or Parent's Name | Spouse or Parent's SS# | Spouse or Parent's Date of Birth

Who Referred You?

Insurance Information *(Please provide a copy of all insurance cards)*

Name of Primary Insurance | Policy # | Group #

Policy Holders Name | Date of Birth | Policy Holder SS# | Relationship to Patient

Employer | Employer Address *(Street, City, State, Zip)*

Secondary Insurance

Name of Secondary Insurance | Policy # | Group #

Policy Holders Name | Date of Birth | Policy Holder SS# | Relationship to Patient

Employer | Employer Address *(Street, City, State, Zip)*

Vision Insurance

Name of Vision Insurance | Policy # | Group #

Policy Holders Name | Date of Birth | Policy Holder SS# | Relationship to Patient

Employer | Employer Address *(Street, City, State, Zip)*

All co-pays (both medical and / or vision) are due at the time services are rendered. A minimum deposit of 50% is due prior to ordering any materials. The balance must be paid in full prior to receiving the materials. *I hereby authorize payment directly to Professional Eye Care Associates, Inc. for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges for services rendered on my behalf or by my dependents, whether or not paid by my insurance. I authorize this office to release any information required to secure the payments of benefits. I authorize the use of my signature below on all insurance submissions. I also realize that I am responsible for any unpaid balances not able to be submitted for insurance payments because I did not present the proper proof of insurance at the time of the appointment. Default of payment will subject account to all collection fees, including court costs and attorneys fees if applicable.*

Signature | Date | Account #

OVER

Primary Care Physician | Phone

Current Medications (prescription/over-the-counter)

Known Allergies (medications or other)

Date of last eye exam (new patients only) | Date of last medical exam

Do you currently wear Eye Glasses: ◯ Yes ◯ No   Do you currently wear Contact Lenses: ◯ Yes ◯ No   Have you had Laser Vision Correction? ◯ Yes ◯ No

Detailed Medical Health History / Do you have now or have you ever had any problems in the following areas? If yes, please explain.

Eyes	
Glaucoma	◯ Yes ◯ No
Cataracts	◯ Yes ◯ No
Macular Disease	◯ Yes ◯ No
Retinal Disease	◯ Yes ◯ No
Color Vision Defect	◯ Yes ◯ No
Loss of Vision	◯ Yes ◯ No
Blurred Vision	◯ Yes ◯ No
Double Vision	◯ Yes ◯ No
Blindness	◯ Yes ◯ No
Flashes / Floaters	◯ Yes ◯ No
Halos / Glare	◯ Yes ◯ No
Dry / Gritty Discomfort	◯ Yes ◯ No
Redness / Discharge	◯ Yes ◯ No
Itching / Burning	◯ Yes ◯ No
Excessive Tearing	◯ Yes ◯ No
Lid Infection Disorder	◯ Yes ◯ No
Eye Strain	◯ Yes ◯ No
Amblyopia / Lazy Eye	◯ Yes ◯ No
Strabismus	◯ Yes ◯ No
Eye Injury	◯ Yes ◯ No
Other	◯ Yes ◯ No
General Health	
Pregnant / Nursing	◯ Yes ◯ No
Weight Change	◯ Yes ◯ No
Chronic Fatigue	◯ Yes ◯ No
Cardiovascular	
Heart Disease	◯ Yes ◯ No
High Cholesterol	◯ Yes ◯ No
Hypertension	◯ Yes ◯ No
Other	◯ Yes ◯ No
Respiratory	
Asthma	◯ Yes ◯ No
Emphysema	◯ Yes ◯ No
COPD	◯ Yes ◯ No
Other	◯ Yes ◯ No

Allergic / Immunologic / Blood / Lymph	
Allergies / Hay Fever	◯ Yes ◯ No
Lupus	◯ Yes ◯ No
Sarcoid	◯ Yes ◯ No
Sjogrens	◯ Yes ◯ No
Anemia	◯ Yes ◯ No
Bleeding Disorder	◯ Yes ◯ No
Hepatitis	◯ Yes ◯ No
HIV / AIDS	◯ Yes ◯ No
Other	◯ Yes ◯ No
Ears / Nose / Throat	
Sinus Condition	◯ Yes ◯ No
Dry Mouth	◯ Yes ◯ No
Chronic Cough	◯ Yes ◯ No
Other	◯ Yes ◯ No
Genital / Urinary	
Kidney Disease	◯ Yes ◯ No
Prostate Condition	◯ Yes ◯ No
Other	◯ Yes ◯ No
Bones / Joints	
Chronic Arthritis	◯ Yes ◯ No
Rheumatoid Arthritis	◯ Yes ◯ No
Osteoporosis	◯ Yes ◯ No
Other	◯ Yes ◯ No
Endocrine	
Diabetes	◯ Yes ◯ No
Thyroid Disease	◯ Yes ◯ No
Other	◯ Yes ◯ No
Neurological	
Headaches / Migraines	◯ Yes ◯ No
Multiple Sclerosis	◯ Yes ◯ No
Other	◯ Yes ◯ No
Other Conditions / Diseases Not Listed	

Family Medical History — *Please list any known family history of diseases (diabetes, stroke, glaucoma, etc.)*

Mother | Father

Siblings | Grandmother | Grandfather

Patient Social History — *Please complete the social history information (your answers are confidential)*

Use of Alcohol ◯ Never ◯ Previously, but quit ◯ Rarely ◯ Regularly How much?____

Use of Tobacco ◯ Never ◯ Previously, but quit ◯ Rarely ◯ Regularly How much?____