

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

H W C

H W C

Primary Phone Secondary Phone 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? _____