PERSONAL EYECARE

Your Best Eyesight Is Our Focus

Welcome to the Office

Today's Date: _____

First Name: _____ MI: _____ Last Name: _____

Mr. Mrs. Ms. Dr. Miss Single / Married If child, parent's name: _____

Nickname: _____ M or F Height: _____ Weight: _____ Blood Pressure: _____

DOB: _____ Preferred Language: _____ Race:_____ Decline _____

Social Security #: _____ Alcohol use: Yes No Tobacco Use: Yes No if yes _____ per day

Address: _____ Apt #: _____ City, State Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-Mail: _____ Communication Preference: e-mail postage telephone texting

How did you hear about us? Insurance List Web Search Sylvania Chamber Friend/Relatives name: _____

Employment Status: Employed Not Employed Student

Employer / School: _____ Occupation / Grade: _____

Family Doctor: _____ City, State Zip: _____

Guarantor Information (Responsible Person)

Name of Primary Insured: _____ Insured Date of Birth: _____ S.S. #: _____

Medical Plan: _____ **Vision Plan:** _____

ID #: _____ _____ ID#: _____

Group #: _____ Group #: _____

Insured Employer: _____

Patient's relationship to insured: Self Spouse Child Other: _____

Secondary Insurance: _____

Consent & Authorization to Release Information

I hereby authorize treatment and the release of any information acquired in the course of my examination or treatment to my referring doctor or insurance company as necessary. I understand that I am financially responsible for services and materials provided to me, including any charges not covered by my insurance policy.

Signature: _____ **Date:** _____

HIPAA PRIVACY POLICY

I have read and understood the information regarding my rights under the HIPAA Privacy Policy, outlining how my health information is utilized.

Signature: _____ **Date:** _____

***Optional*:** If it is necessary for someone other than yourself to discuss your medical conditions, bills or finances with Personal Eyecare, please provide the individual's name below to appoint and authorize them to act as your personal representative for this limited purpose. Should you decide to change this authorization you may contact us at any time.

_____ _____

Name of personal representative **Relationship**

ASK ABOUT OUR PATIENT PORTAL

Ocular History

Reason for visit today:

_____

Do you wear glasses: YES NO

All the time Distance only Reading only

Do you wear contacts: YES NO

If yes: Gas Perm Soft Daily Monovision Bifocal

Brand: _____ Age of current lenses: _____

Replacement schedule: Daily 2 week Monthly Yearly

If no, are you interested in contacts? YES NO

List any eye drops you use? _____

Are you experiencing?

□ Blurry Vision	□ Burning eyes	□ Light sensitivity
□ Poor night vision	□ Scratchy feeling	□ Daytime glare
□ Itching eyes	□ Dry eyes	□ Nighttime glare
□ Light flashes	□ Eye Pain/Soreness	□ Tearing
□ Floaters	□ Eye Strain	□ Headaches
□ Double vision	□ Tired eyes	□ Grittiness

Past/Present Ocular History

Have ***you*** been diagnosed, treated or had surgery for:

		Diagnosed or Surgery Date
Cataracts	Yes No	
Corneal Abrasion	Yes No	
Diabetic Retinopathy	Yes No	
Eye Injury	Yes No	
Glaucoma	Yes No	
Iritis/Uveitis	Yes No	
Lazy Eye	Yes No	
Macular Degeneration	Yes No	
Retinal Detachment	Yes No	
Other: _____ _____	Yes No	

Family History

List "WHO" next to disease/condition, ie, mother/father, siblings or maternal/paternal grandparent

Systemic	Relationship
High Blood Pressure	
Diabetes	
Cancer: (Type)	
Heart Disease	
Other: _____	

Ocular	Relationship
Cataracts	
Glaucoma	
Diabetic Retinopathy	
Macular Degeneration	
Retinal Detachment	
Other: _____	

Medical History

System		Medication	Dosage
Cardiovascular:			
Hypertension			
High Blood Pressure	Yes No		
High Cholesterol	Yes No		
Stroke	Yes No		
Other: _____			
Endocrine:			
Diabetic: Type1 or Type2	Yes No		
How Long: _____			
Thyroid	Yes No		
Gout	Yes No		
Other: _____			
Gastrointestinal:			
Crohn's	Yes No		
GERD	Yes No		
Other: _____			
Hematologic/Lymphatic:			
Anemia	Yes No		
Leukemia	Yes No		
Other: _____			
Integumentary: Skin			
Eczema	Yes No		
Rosacea	Yes No		
Skin Cancer	Yes No		
Other: _____			
Musculoskeletal:			
Fibromyalgia	Yes No		
Muscular Dystrophy	Yes No		
Arthritis	Yes No		
Other: _____			
Neurological:			
Epilepsy	Yes No		
Cerebral Palsy	Yes No		
MS	Yes No		
Other: _____			
Psychiatric:			
ADHD	Yes No		
Anxiety	Yes No		
Depression	Yes No		
Other: _____			
Drug Allergies: List	Yes No		
Environmental Allergies:	Yes No		

Major Surgeries: _____

List & Date _____

_____