82nd EyeCare

PATIENT INFORMATION

Title:___ First Name:_____ MI:___ Last Name:_____ Nickname:_____

Address:_____ City:_____ State:_____ Zip:_____

Preferred Method of Contact:

Home Phone:_____ Cell Phone:_____ Work Phone:_____ ☐Home ☐Cell ☐Work ☐Email

Birth Date:____/____/_____ Sex: ☐M ☐F Social Security #:_____ E-Mail:_____

Month Day Year

Marital Status: ☐Single ☐Married ☐Other:_____ Employment: ☐Full-Time ☐Part-Time

Occupation:_____ Hobbies:_____

Employer:_____ Phone:_____ How did you hear about us?_____

Guardian Name:_____ Relationship:_____ Phone:_____

Primary Care Physician:_____ Phone:_____ Date of Last Physical:_____

RESPONSIBLE PARTY (if Patient is under 18 years of age)

Title:___ First Name:_____ MI:___ Last Name:_____ Relationship:_____

Address:_____ City:_____ State:_____ Zip:_____

Preferred Method of Contact:

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

Birth Date:____/____/_____ Social Security #:_____ Sex: ☐M ☐F Employer/School:_____

PATIENT INSURANCE INFORMATION

Primary Vision Insurance: _____ ID#: _____ Group#: _____
Insured: ☐Self ☐Spouse ☐Parent ☐Other Insured's Name: _____ Insured's DOB: _____

Secondary Vision Insurance: _____ ID#: _____ Group#: _____
Insured: ☐Self ☐Spouse ☐Parent ☐Other Insured's Name: _____ Insured's DOB: _____

Primary Medical Insurance: _____ ID#: _____ Group#: _____
Insured: ☐Self ☐Spouse ☐Parent ☐Other Insured's Name: _____ Insured's DOB: _____

Medicare Part B Insurance? ☐No ☐Yes - *Photocopy of Card Required*
Medicare Supplemental Insurance? ☐No ☐Yes - *Photocopy of Card Required*

HIPAA PRIVACY RULE

I acknowledge receipt of the Notice of Privacy Practices, and have been offered a copy to keep for my records.

Signature of Patient or Guardian: _____ Date: _____

FINANCIAL AGREEMENT AND SIGNATURE ON FILE

I understand that I must pay in full at the time of exam, unless my insurance benefits have been verified by 82nd EyeCare prior to my appointment. I agree to be responsible for any balance not paid by my insurance company due to eligibility status or any other reason. I understand that there is a $25 returned check fee, that a 1.5% finance charge will be added monthly to any unpaid balances, and that unpaid balances will be turned over to a collection agency. My signature below constitutes my consent for "signature on file" notation for the purpose of insurance filings, and certifies that the information I provided is correct.

Signature of Patient or Guardian: _____ Date: _____

VISUAL HISTORY

Date Of Last Eye Exam: _____

Previous Eye Doctor: _____ Phone: _____

Do You Wear Glasses? ☐No ☐Yes ☐In The Past

Do You Wear Contact Lenses? ☐No ☐Yes ☐In The Past

Are You Interested In New Contact Lens Options? ☐No ☐Yes

Do You Use Computers? ☐No ☐Yes; Hours Per Day: _____

Previous Eye Surgery: ☐No ☐Yes: _____

Previous Eye Injury: ☐No ☐Yes: _____

FAMILY HISTORY

Did Any Of Your Blood Relatives Have:

Cataracts: ☐No ☐Yes

Glaucoma: ☐No ☐Yes: Who? _____

Macular Degeneration: ☐No ☐Yes: Who? _____

SOCIAL HISTORY

Do You Use Tobacco?

☐No

☐Yes: How Often? _____

☐In The Past

MEDICAL HISTORY

List All Medications (Prescription, OTC, Supplements): _____

_____

Are You Allergic To Any Medications? ☐No ☐Yes: _____

Are You Pregnant Or Nursing? ☐No ☐Yes: _____

REVIEW OF SYSTEMS

Do You Currently Have, Or Have Ever Had, The Following Problems?

	YES	NO
EYES		
Blurred Vision	☐	☐
Eye Fatigue	☐	☐
Double Vision	☐	☐
Crossed or Turned Eye	☐	☐
Lazy or Amblyopic Eye	☐	☐
Light Sensitivity	☐	☐
Red or Infected Eye	☐	☐
Dry or Watery Eye	☐	☐
Scratchy or Painful Eye	☐	☐
Itchy Eye	☐	☐
Spots or Floaters	☐	☐
Flashes of Light	☐	☐
Cataract	☐	☐
Glaucoma	☐	☐
Macular Degeneration	☐	☐
Retinal Detachment	☐	☐
EARS, NOSE, THROAT		
Sinusitis	☐	☐
Vertigo	☐	☐
CARDIOVASCULAR		
High Blood Pressure	☐	☐
High Cholesterol	☐	☐
Stroke	☐	☐
RESPIRATORY		
Asthma	☐	☐
Sleep Apnea	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
GENITAL/KIDNEY/BLADDER		
Kidney problems	☐	☐
Enlarged Prostate	☐	☐

	YES	NO
MUSCLES/BONES/JOINTS		
Arthritis	☐	☐
Fibromyalgia	☐	☐
GASTROINTESTINAL		
Crohn's	☐	☐
Irritable Bowel Syndrome (IBS)	☐	☐
SKIN		
Rosacea	☐	☐
Eczema	☐	☐
Psoriasis	☐	☐
NEUROLOGICAL		
Headache	☐	☐
Migraine	☐	☐
Concussion	☐	☐
Brain Injury	☐	☐
Multiple Sclerosis	☐	☐
Seizures	☐	☐
PSYCHIATRIC		
Attention Deficit Disorder	☐	☐
Depression	☐	☐
Anxiety	☐	☐
ENDOCRINE		
Diabetes	☐	☐
Hyperthyroid	☐	☐
Hypothyroid	☐	☐
BLOOD/LYMPHATIC		
Anemia	☐	☐
Bleeding disorder	☐	☐
ALLERGIC/IMMUNOLOGIC		
Seasonal Allergies	☐	☐
GENERAL		
Other:_____	☐	☐