PATIENT INFORMATION

Patient Name:_____ Age:_____
LAST FIRST MI

Patient Address:_____ City: _____ State:_____Zip:_____

Home #: (_____) _____ - _____ Cell #: (_____) _____ - _____ Work #: (_____) _____ -_____

Date of Birth: _____ / _____ / _____ Sex: ☐M ☐F

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Name of Responsible Party: (☐self)_____ Relationship to patient:_____

REFERRED BY: ☐ Doctor :_____ ☐Insurance ☐Friend/Family ☐Yellowpages
☐Internet ☐ ER ☐Urgent Care ☐Lecture ☐ Daleel ☐ Flyer ☐ Other_____

PRIMARY INSURANCE (if applicable)

Primary Insurance:_____ ☐ Self Pay ☐ HMO ☐ PPO ☐Workers Comp

☐Check here if primary insurance holder is the patient, then you may skip to the next section

Name of Primary Policyholder: _____ Date of Birth: ___ / ____ / ____

Relationship of Patient to Policyholder: ☐SELF ☐WIFE ☐HUSBAND ☐CHILD ☐OTHER

Billing Address:(☐Same as Patient Address):_____

SECONDARY INSURANCE (if applicable)

Secondary Insurance:_____ ☐ HMO ☐ PPO ☐ POS ☐EPO

☐Check here if secondary insurance holder is the patient, then you may skip to the next section

Name of Primary Policyholder: _____ Date of Birth: ___ / ____ / ____

Relationship of Patient to Policyholder: ☐SELF ☐WIFE ☐HUSBAND ☐CHILD ☐OTHER

Billing Address:(☐Same as Patient Address)_____

AUTHORIZATION and HIPPA PRIVACY NOTICE

Please Read:

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment.

I understand if I have insurance and have provided accurate and complete information regarding my insurance, my charges will be filed with my insurance carrier; however, the financial responsibility for services rendered to a patient ultimately rests with the patient or responsible party. I understand that my copay and/or any coinsurance monies are due at the time of service. Should my insurance carrier require a referral and I fail to provide one, I agree to pay for all charges associated with the care provided by Premier Eye Center. In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to me, I agree to pay all reasonable attorney's fees and any other court costs or costs of collection. I hereby authorize assignment and payment directly to Premier Eye Center any major medical benefits due me for services provided by them.

X_____ _____
Signature of Responsible Party Date

HIPPA STATEMENT

I have read and agree with Premier Eye Center's ***HIPPA Notice of Privacy Policy.***

I hereby authorize Premier Eye Center to furnish to my insurance company or authorizing agency information regarding my protected health information for the purposes of treatment, payments, or health care operations. I further authorize the physician(s) of Premier Eye Center to consult as needed in their sole discretion with other medical providers regarding my medical care.

X_____ _____
Signature of Responsible Party Date

MEDICAL HISTORY FORM

Patient Name: _____

MEDICAL HISTORY: ***DO YOU HAVE?***

DIABETES: …….. **yes** ☐ no ☐
If yes, for how many years? _____
Highest blood sugar within the past month? _____
Any breathing problem: ……..... **yes** ☐ no ☐
High blood pressure: ……... **yes** ☐ no ☐
HIV: ……... **yes** ☐ no ☐
History of cancer: …….. **yes** ☐ no ☐ → If yes, type/date_____
Previous stroke: …….. **yes** ☐ no ☐
LIST any other medical problem(*s*)→1)_____ 2)_____ 3)_____4)_____ ☐ **NONE**

CURRENT EYE PROBLEM:

Do you have any **eye pain**? …… **yes** ☐ no ☐ → When did it start? _____ → Which eye? _____
Are you having **blurry vision**? ……...**yes** ☐ no ☐ → When did it start? _____ → Which eye? _____
Do you experience seeing black spots, shadows, or shapes (i.e. **floaters**)?.. **yes** ☐ no ☐ → Which eye? _____
Do you experience seeing **flashes of light**? ……. …..**yes** ☐ no ☐ → Which eye? _____

PAST EYE HISTORY

Do you have any **eye disease?**…… **yes** ☐ no ☐
If yes, please explain:_____
When was your **last eye exam**? _____ ago
Do you use **contact lenses:** ……..... **yes** ☐ no ☐
Do you wear **glasses**? ……. **yes** ☐ no ☐ → ☐ check here if glasses are **only** for reading
Do you have a **lazy eye**? …… **yes** ☐ no ☐ → Which eye? Right ☐ Left ☐ Both ☐
Ever been **hit in your eye**?.. **yes** ☐ no ☐ → Which eye? Right ☐ Left ☐ Both ☐
Have you had eye **surgery** before?..... **yes** ☐ no ☐ → Which eye? Right ☐ Left ☐ Both ☐
If yes, please provide details and dates below:
_____
Have you had **laser** eye surgery?..... **yes** ☐ no ☐ → Which eye? Right ☐ Left ☐ Both ☐
If yes, please provide details and dates:_____

EYE DROPS: (list all eye drops you use currently and how often you use them**).** ☐ **NONE**

_____ _____
_____ _____

MEDICATIONS (PILLS): (only write down the name, NOT the dose)**……...** ☐ **NONE**

_____ _____ _____
_____ _____ _____

ALLERGIES: Are you **allergic** to any medicine:……**yes** ☐ no ☐
If yes, please provide name(s) of the medicine(s)→→

FAMILY AND SOCIAL HISTORY:

Anyone in your family have **glaucoma**?..... **yes** ☐ no ☐ If yes, who: _____
Is anyone in your family **cross-eyed**?..... **yes** ☐ no ☐
Any **eye disease** that runs in your family?.....**yes** ☐ no ☐ If yes, please explain:_____
Do you smoke?..... **yes** ☐ no ☐ →→ Do you drink?.....**yes** ☐ no ☐

GENERAL MEDICAL QUESTIONS: (Do you have the following?)

Fever:……**yes** ☐ no ☐
Frequent Headaches: …… **yes** ☐ no ☐
Are you pregnant: ……**yes** ☐ no ☐
Muscle weakness: ……**yes** ☐ no ☐
Numbness: …… **yes** ☐ no ☐
Rash: ……**yes** ☐ no ☐
Cough: ……..... **yes** ☐ no ☐
Have you had a heart attack: …… **yes** ☐ no ☐
History of Tuberculosis: ……..**yes** ☐ no ☐
Hepatitis C…… **yes** ☐ no ☐

Diarrhea: …… **yes** ☐ no ☐
Blood in your stool: ……..…… **yes** ☐ no ☐
Recent weight loss: …… **yes** ☐ no ☐
Recent decreased appetite: ……..…. **yes** ☐ no ☐
Pain when you urinate: ……..… **yes** ☐ no ☐
Joint pain: …….. **yes** ☐ no ☐
Muscle pain: …….. **yes** ☐ no ☐
Low back pain: …….. **yes** ☐ no ☐

_____ _____
SIGN HERE DATE