Patient Information

Name _____
First Middle Last
Address _____
PO Box _____
City_____ State _____ Zip _____
Phone: Home _____ Cell _____
Work _____
Date of Birth _____ Age _____ Sex: M F

Social Security Number: _____
Employer/School: _____
Occupation: _____
Marital Status: Single Married Widowed Divorced

Insurance Information

(this must be completed to file a claim)

Vision Plan: _____
Medical Insurance:_____
Name of Primary Insured: _____
Insured Employer: _____
Insured Date of Birth: _____
Insured SS# _____
Insured Address (if different) _____
Pt.'s relationship to insured: Self Spouse Child Other

New Patients: Who referred you to our practice?
Reason for today's visit? _____
_____

Privacy Practices & Financial Responsibility

I acknowledge that a copy of Professional Eye Care's Notice of Privacy Practices has been made available to me. I agree to be responsible for any fees incurred as a result of failure to pay for all services and/or materials provided, including reasonable collection fees.

Signature: _____ **Date** _____
(self, parent or guardian)

↓↓↓ Office Use Only ↓↓↓ Office Use Only ↓↓↓ Office Use Only ↓↓↓ Office Use Only ↓↓↓

PERSONAL Medical & Social History

- □ Heart Disease
- □ Stroke
- □ Thyroid
- □ Skin
- □ STD
- □ Smoker
- □ Cancer
- □ High Blood Pressure
- □ Diabetes:type I II
- □ Headache:more than 1x w
- □ Allergies
- □ Neurological
- □ Gastrointestinal
- □ Psychiatric
- □ Ear, Nose, Throat
- □ Respiratory
- □ Blood Disorder
- □ Hormonal
- □ Musculoskelatal
- □ Develop. Disability
- □ other _____
- □ Drug allergies?_____

FAMILY Medical History

- □ Diabetes
- □ Heart Disease
- □ High Blood Pressure
- □ Macular Degeneration
- □ Other _____
- □ Glaucoma
- □ Cancer
- □ Cataracts

Our I - Wellness Exam is an enhanced level of service that is NOT covered by routine insurance plans. However, the doctors of PEC recommend this form of Retinal Imaging for ALL their patients. This I - Wellness program provides specialized documentation of eye health for future reference and, in most cases, helps the patient to avoid the inconvenience of pupil dilation.

□ **YES-** I want the I - Wellness Exam service today and will self pay $38
□ **NO-** I prefer the use of dilation drops for my Retinal Exam.

Signature: _____ **Date** _____

Ocular History/Problems

- □ Glaucoma
- □ Macular Degeneration
- □ Dryness
- □ Burning
- □ Light Sensitive
- □ Floaters
- □ Night Driving Problems
- □ Cataracts
- □ Eye Surgery
- □ Blurred Vision
- □ Discharge
- □ Flashes of Light
- □ Computer vision problems
- □ Headaches
- □ Reading Difficulty

□ Other _____
_____

Are you happy with your current eyeglasses ? Yes No
Are you happy with your current contact lenses ? Yes No
if not, explain: _____

Current Medications (include over the counter)

Medication	Reason for taking
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

continue on back of this sheet if needed ---------->

Family Doctor: _____
Phone: _____

Reviewed by Dr. _____ /_____ / _____