EyeCare Professionals

"Where healthy eyes are our focus."

Patient Information

Please print all information

Patient_____ **SS#**_____ **Date**_____

Address_____**City**_____ **State**_____ **Zip**_____

Home Phone_____ **Cell Phone**_____ **Work Phone**_____

May we contact you by text message? ☐ **Yes** ☐ **No**

Email Address: _____

What is the best way and time to contact you? _____

Occupation_____ **Employer**_____

Date of Birth_____ **Age**_____ **GENDER: MALE FEMALE**

MARITAL STATUS: SINGLE MARRIED WIDOWED SEPARATED DIVORCED

ETHNICITY: AFRICAN AMERICAN CAUCASIAN HISPANIC ASIAN OTHER

Name of insurance policy_____ **Whose name is the insurance in?** _____

Relationship to patient? _____ **Address of policy holder (If different from above)** _____

City _____**State**_____ **Zip** _____

DOB of insurance holder _____**SS# of insurance holder** _____

Policy holder phone #_____**Employer of policy holder:** _____

Emergency contact information. Please tell us who may know your private information.

1. **Name**_____**Relationship**_____**Phone number**_____
2. **Name**_____**Relationship**_____**Phone number**_____
3. **Name**_____**Relationship**_____**Phone number**_____

Please read and sign in the two places provided.

I acknowledge that a copy Eyecare Professional's, P.C. notice of privacy practices is available to me and if I would like one I may take one. ***Sign below*:**

➡ ***Patient/Parent Signature*** _____ ***Relationship*** _____ ***Date*** _____ ⬅

This document is to serve as my signature on file. I authorize payment of my insurance benefits to Eyecare Professionals, P.C. All professional fees must be paid at time of services. If insurance coverage is denied or I am ineligible for benefits at the time of service, I understand that I will be held responsible for all services and materials. Any charges that are acquired and are not covered by my insurance company will be my responsibility.

➡ ***Patient/Parent Signature*** _____ ***Relationship*** _____ ***Date*** _____ ⬅

Eye Health History

Do you CURRENTLY have any problems in the following areas?

Loss of Vision	**YES**	**NO**	**Glare/Light Sensitivity**	**YES**	**NO**
Blurred Vision	**YES**	**NO**	**Eye Pain or Soreness**	**YES**	**NO**
Distorted Vision/Halos	**YES**	**NO**	**Chronic Infection of Lid or Eye**	**YES**	**NO**
Loss of Side Vision	**YES**	**NO**	**Crossed Eyes**	**YES**	**NO**
Double Vision	**YES**	**NO**	**Flashes or Floaters in Vision**	**YES**	**NO**
Dryness	**YES**	**NO**	**Blackouts/Fainting Spells**	**YES**	**NO**
Mucous Discharge	**YES**	**NO**	**Headaches**	**YES**	**NO**
Redness	**YES**	**NO**	**Tired Eyes**	**YES**	**NO**
Sandy or Gritty Feeling	**YES**	**NO**	**Twitching Eyelid**	**YES**	**NO**
Itching	**YES**	**NO**	**Poor Color Vision**	**YES**	**NO**
Burning	**YES**	**NO**	**Lazy Eye**	**YES**	**NO**
Foreign Body Sensation	**YES**	**NO**	**Retinal Disease**	**YES**	**NO**
Excess Tearing/Watering	**YES**	**NO**	**Cataracts**	**YES**	**NO**

Eye injury and explain_____

Eye surgery and explain_____

- **Date of Last Eye Exam: _____**
- **Name of last eye doctor: _____**
- **Do you already wear eyeglasses? YES / NO**
- **Do you want new eyeglasses: YES / NO**
- **Do you already wear contacts? YES/NO**
- **Are you interested in being fit with contacts? YES/ NO**
- **What kind of contacts do you wear? _____**
- **Are your contacts comfortable? YES / NO**

Allergies: _____

_____

List any medications you currently take; including contraceptives, any over the counter medications, and eye drops:

_____

_____

_____

_____

- **Are you pregnant? YES or NO If yes how many weeks? _____**
- **Do you drive? YES or NO-----If yes, do you have visual difficulty when driving? YES or NO**
- **If yes, please describe: _____**
- **Do you use tobacco products? YES or NO How much daily? _____ How long? _____**
- **Do you use alcohol? YES or NO Amount? _____**
- **Do you use illegal drugs? YES or NO What kind? _____**

Patient and Family Medical History

Medical/Family Doctor: _____ Date of Last Visit: _____

Please carefully read the following and CIRCLE yes or no. All of these conditions and medications to treat these conditions affect your eyes.

	SELF			BLOOD RELATIVES		
			Year Diagnosed			Family Member
Alzheimer's Disease/Dementia	YES	NO	_____	YES	NO	_____
Blindness	YES	NO	_____	YES	NO	_____
Glaucoma	YES	NO	_____	YES	NO	_____
Macular Degeneration	YES	NO	_____	YES	NO	_____
Retinal Disease	YES	NO	_____	YES	NO	_____
Arthritis	YES	NO	_____	YES	NO	_____
Breast Cancer	YES	NO	_____	YES	NO	_____
Colon Cancer	YES	NO	_____	YES	NO	_____
Lung Cancer	YES	NO	_____	YES	NO	_____
Prostate Cancer	YES	NO	_____	YES	NO	_____
Skin Cancer	YES	NO	_____	YES	NO	_____
Stomach Cancer	YES	NO	_____	YES	NO	_____
Diabetes	YES	NO	_____	YES	NO	_____
Heart Disease	YES	NO	_____	YES	NO	_____
High Blood Pressure	YES	NO	_____	YES	NO	_____
Kidney Disease	YES	NO	_____	YES	NO	_____
Lupus	YES	NO	_____	YES	NO	_____
Thyroid Disease	YES	NO	_____	YES	NO	_____
AIDS/HIV	YES	NO	_____	YES	NO	_____
Blood Disorders	YES	NO	_____	YES	NO	_____
Epilepsy	YES	NO	_____	YES	NO	_____
Hepatitis (Type_____)	YES	NO	_____	YES	NO	_____
Pacemaker	YES	NO	_____	YES	NO	_____
Rheumatic Fever	YES	NO	_____	YES	NO	_____
Stroke	YES	NO	_____	YES	NO	_____
Shingles	YES	NO	_____	YES	NO	_____
Tuberculosis	YES	NO	_____	YES	NO	_____
Asthma	YES	NO	_____	YES	NO	_____
Emphysema	YES	NO	_____	YES	NO	_____
Allergies/Hay Fever	YES	NO	_____	YES	NO	_____
Seizures	YES	NO	_____	YES	NO	_____
High Cholesterol	YES	NO	_____	YES	NO	_____
Sleep Apnea	YES	NO	_____	YES	NO	_____

Are there any other problems, conditions, or surgeries you would like to include? _____

_____