



## Patient & Insurance Information

Patient Name (Last) \_\_\_\_\_  
(First) \_\_\_\_\_ Middle Initial \_\_\_\_\_

Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Home # ( ) \_\_\_\_\_

Work # ( ) \_\_\_\_\_

Cell # ( ) \_\_\_\_\_ Texting is OK \_\_\_\_\_

E-Mail \_\_\_\_\_

Sex:  M  F Age \_\_\_\_\_

Marital Status:  Married  Single  Minor

Occupation \_\_\_\_\_

Patient Employer/School \_\_\_\_\_

### VISION INSURANCE

Insurance Co. \_\_\_\_\_

Insured's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to patient \_\_\_\_\_

### MEDICAL INSURANCE

Insurance Co. \_\_\_\_\_

Insured's Name \_\_\_\_\_  (Same as above)

Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

### Name of Parent or Guardian of Minor Child

Name \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

I prefer to be contacted by \_\_\_ Phone \_\_\_ Postal \_\_\_ Email

## Eye Health History

Date of Last Eye Exam \_\_\_\_\_

Name of Eye Doctor \_\_\_\_\_

Do you wear glasses?  Yes  No

All the time  Occasionally

Reading  Driving  TV

Do you wear contacts?  Yes  No

Type \_\_\_\_\_ Hours/Day \_\_\_\_\_

Please place a **check** in the box to indicate if you have any of the following.

- |  |   |
|--|---|
| Blurred Vision - Distance <input type="checkbox"/> | Floaters or Spots <input type="checkbox"/>        |
| Blurred Vision - Near <input type="checkbox"/>     | Glaucoma <input type="checkbox"/>                 |
| Burning Eyes <input type="checkbox"/>              | Headaches <input type="checkbox"/>                |
| Cataracts <input type="checkbox"/>                 | Itching Eyes <input type="checkbox"/>             |
| Color Vision, Poor <input type="checkbox"/>        | Light Sensitive <input type="checkbox"/>          |
| Crossed Eyes <input type="checkbox"/>              | Loss of Vision <input type="checkbox"/>           |
| Discharge from Eye <input type="checkbox"/>        | Night Vision, Poor <input type="checkbox"/>       |
| Dizzy Spells <input type="checkbox"/>              | Red Eyes <input type="checkbox"/>                 |
| Double Vision <input type="checkbox"/>             | Seeing Halos <input type="checkbox"/>             |
| Dry Eyes <input type="checkbox"/>                  | Seeing Flashes <input type="checkbox"/>           |
| Eye Infection <input type="checkbox"/>             | Temporary loss of vision <input type="checkbox"/> |
| Eye Injury <input type="checkbox"/>                | Twitching Eyelid <input type="checkbox"/>         |
| Eye Strain <input type="checkbox"/>                |   |

## Medications Allergies

List any medications you are currently taking, including eye drops:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Phone ( ) \_\_\_\_\_

List your allergies to medications or other substances:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Health History

Primary Care Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Please place a **check** in the box to indicate if you have had any of the following. Also place a **check** to indicate if a blood relative has had any of the following problems.

	<u>Yourself</u>	<u>Family</u>	<u>Which Family Member</u>		<u>Yourself</u>	<u>Family</u>	<u>Which Family Member</u>	
AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	_____		Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____		Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____		Lupus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____		Migraine Headache	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____		Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____		Poor Color Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____		Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____		Shingles	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____		Skin Conditions	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____		Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____		Thyroid Conditions	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____		Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____		Alcohol Use	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____		Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis (Type _____)	<input type="checkbox"/>	<input type="checkbox"/>	_____		Number of Children	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____					

## Assignment, Release, and Financial Policy

I certify that I, and/or my dependent(s), have insurance coverage with the above-named Insurance Company(ies) and assign directly to **Distinctive Eye Care** all insurance benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

**Distinctive Eye Care** may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I acknowledge that I received a copy of Distinctive Eye Care's Notice of Privacy Practices (please inquire if you have not read the HIPPA privacy notice).

We collect an optional \$10 Administrative Services Fee annually. This fee covers completion of forms requested >1 month after service. This includes patient requested reports, school forms, exam copies, etc. (for a complete list, please inquire).

\_\_\_\_ I choose to pay the \$10 Administrative Fee.

\_\_\_\_ I decline the Administrative Fee. I understand that I will pay for completion of documents as I need them.

\_\_\_\_\_  
Signature of Patient (or Guardian)