Last Name: _____ First Name: _____ M_____ DOB: ____ /____ /____

Male or Female SSN or Last 4: _____ Marital Status: Married / Single / Other _____

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

Home Ph: (_____) _____ Work Ph: (_____) _____ Cell Ph: (_____) _____

Employer/School: _____ Occupation/School Grade: _____

Email Address: _____ Sports/Hobbies: _____

Emergency Contact: _____ Relation: _____ Phone #: (_____) _____

Insurance Information (Please give your card to front desk)

Name of Medical Insurance _____ Name of Vision Insurance _____

Primary Insured's Name _____ Identification Number _____

Group Number _____ DOB: _____/_____/_____

Date of Last Eye Exam: ____/____/____ **Clinic/Eye Doctor**_____

HPI (History of Present Illness)

___Age Related Macular Deg
___Blurred Vision
___Bothersome Night Glare
___Burning
___Cataract
___Conjunctivitis (pink eye)
___Diabetes
___Diabetic retinopathy
___Discharge
___Double Vision
___Dry Eye
___Eye Strain
___Glaucoma
___Headache
___Iritis
___Itching
___Poor Night Vision
___PVD-Floaters
___Redness
___Retina
___Severe Sensitivity to Lights
___Tearing
___Total Loss of Vision

ROS (Medical History)

___Constitution (cancer, disabilities, fatigue syndrome)
___ ENT (hearing loss, dry mouth, sinusitis, laryngitis)
___Neurological (seizures, migraine etc.)
___Psychiatric (depression, anxiety, etc.)
___Cardiovascular (stroke, heart disease, etc.)
___Respiratory (asthma, bronchitis, etc.)
___Allergies/Immune Disorders

Past Ocular Hx

___Age Related Macular Deg
___Surgery
___Patching
___Inflammatory Disorder
___Strabismus (cross-eyed)
___Amblyopia (lazy eye)
___Retinal Degen/Hole/Detach.
___Keratoconus
___Injury
___Dry Eye
___Nystagmus (uncontrolled eye movement)

Allergic to Medications? Yes No
List: _____
Taking any Medications? Yes No
List: _____

Family Medical Hx

Cancer	Yes	No	If yes, _____
Diabetes Mellitus	Yes	No	If yes, _____
Diabetes Type 1	Yes	No	If yes, _____
Diabetes Type 2	Yes	No	If yes, _____
Hypertension	Yes	No	If yes, _____
Hyperthyroidism	Yes	No	If yes, _____
Hypothyroidism	Yes	No	If yes, _____

Family Ocular Hx

Cataract	Yes	No	If yes, _____
Macular Degen.	Yes	No	If yes, _____
Glaucoma	Yes	No	If yes, _____

Optical Hx

Glasses? Distance, Near, Both, None
Contact Len? Distance, Near, Both, None
If yes, brand? _____

Social Hx

Drink? Yes No
Smoke? Yes No

How can we improve your eyewear?

_____
_____

Insurance Authorization/HIPPA Notice

___I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners.
I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me.
I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.
___I acknowledge that I had the opportunity to review and have received a copy if so desired of **The Eyecare Place, Llc**. Notice of Privacy Practices

Signature _____ **Date** _____