Eye Care And Surgery, P.C.

Patient Name: _____ **DOB:** _____

Medical History / Review of Systems:

List any medications you are now taking **(including eye drops and birth control pills):**

_____

_____

Are you allergic to any medications? ☐ Yes ☐ No Please list: _____

Primary Care Physician: _____ Pediatrician: _____

Endocrinologist (if diabetic): _____

Preferred Pharmacy: _____ Location: _____

Do you currently have any of the following conditions:

☐ No ☐ Yes Asthma/COPD

☐ No ☐ Yes Diabetes

☐ No ☐ Yes High Blood Pressure

☐ No ☐ Yes High Cholesterol

☐ No ☐ Yes Thyroid Conditions

☐ No ☐ Yes Pregnant/Nursing

☐ No ☐ Yes Arthritis

☐ No ☐ Yes Chronic fever, unexpected weight loss/gain, fatigue)

☐ No ☐ Yes Ear/nose/throat (hearing loss, sinus)

☐ No ☐ Yes Endocrine Conditions

☐ No ☐ Yes Gastrointestinal Conditions (ulcer, abdominal pain, diarrhea)

☐ No ☐ Yes Heart Conditions

☐ No ☐ Yes Musculoskeletal Conditions

☐ No ☐ Yes Neurologic (numbness, , weakness, headaches, prior stroke)

☐ No ☐ Yes Psychiatric Conditions (depression, anxiety)

☐ No ☐ Yes Respiratory Conditions (shortness of breath, wheezing)

☐ No ☐ Yes Seasonal Allergies

☐ No ☐ Yes Skin Conditions (rashes, excessive dryness, rosacea)

☐ No ☐ Yes Urinary Conditions (pain or discomfort, blood in urine)

☐ Other Condition/Illness _____

List any previous major injuries/surgeries/hospitalizations: _____

Any prenatal, perinatal, or postnatal problems? ☐ Yes ☐ No _____

Smoking History:

☐ Current Every Day Smoker ☐ Current Some Day Smoker ☐ Former Smoker ☐ Never Smoker ☐ Smoker (Current Status Unknown)

Do you drink alcohol? ☐ Yes ☐ No _____ Do you use illegal drugs? ☐ Yes ☐ No _____

Have you ever been exposed to or infected with: ☐ HIV ☐ Hepatitis

Vaccination: ☐ Flu ☐ Pneumonia (65 yrs +)

Family History (Please use the checkboxes to indicate who in your family had the condition.)

	Parent	Sibling	Child		Parent	Sibling	Child
Blindness	☐	☐	☐	High Blood Pressure	☐	☐	☐
Cataract	☐	☐	☐	Lazy/Crossed Eye	☐	☐	☐
Diabetes	☐	☐	☐	Macular Degeneration	☐	☐	☐
Glaucoma	☐	☐	☐	Retinal Detachment	☐	☐	☐
Other Eye Disease or Condition: _____					☐	☐	☐

Eye History: Do you have or have you ever had any of the following conditions?

☐ Blurred Vision ☐ Cataracts ☐ Double Vision ☐ Dry Eye ☐ Eye Injury ☐ Flashes ☐ Floaters ☐ Glaucoma

☐ Lazy/Crossed Eye ☐ Loss of Vision ☐ Macular Degeneration ☐ Migraine/Headache ☐ Retinal Detachment

☐ Eye Surgery _____

OVER PLEASE →

Do you drive? ☐ Yes ☐ No If yes, do you have visual difficulty when driving? ☐ Yes ☐ No If yes, please describe: _____

_____

Last eyecare provider: _____ Date of last eye exam _____

Are you currently having eye or vision problems? ☐ Yes ☐ No

If yes, please explain _____

Do you wear glasses? ☐ Yes ☐ No How old are they?____ Are they bifocals? ☐ Yes ☐ No Are they for ☐ Reading ☐ Distance ☐ Both

Have you ever worn contact lenses? ☐ Yes ☐ No If yes, when were they prescribed? _____

Do you wear contacts now? ☐ Yes ☐ No If not, why did you quit? _____

Are you interested in wearing contact lenses? ☐ Yes ☐ No If yes, please read the following information regarding contact lenses.

Eye Care & Surgery, P.C. prescribes quality contact lenses to improve your vision and your lifestyle. Contact lenses are FDA regulated medical devices that can cause discomfort, infections, and even permanent vision loss if not cared for properly. New and existing contact lens wearers require additional time and testing during an eye examination to minimize the risk of serious eye problems. This additional testing is only done for contact lens wearers, not for patients who do not wear contact lenses. For this reason, there are additional contact lens evaluation and services fees for new and existing contact lens wearers. Your contact lens evaluation and services fee includes:

1. Specific curvature measurements of the corneas
2. Evaluation of current and new lenses to ensure optimal fit, vision and comfort
3. Medical assessment of the cornea, tear film and conjunctiva as they relate to contact lens wear
4. Instructions regarding safe contact lens wear, care and proper cleaning and solutions
5. Contact lens follow up care for 90 days

If you have any questions, please do not hesitate to speak with your doctor.

Payment for all services and products is the responsibility of the patient.

I agree to pay all copays, deductibles, co-insurances and non-covered services as determined by my insurance company.

I understand there is a returned check fee applied to every returned check.

I agree to pay an additional 25% of the amount owed as a collection fee for all accounts not paid in the time stated on the final monthly statement.

I authorize the release of medical information concerning my illness and treatment by Eye Care & Surgery, P.C. to my insurance company.

I also authorize the release of my personal medical information to any doctor whom I may be referred to.

I understand verification of eligibility is not a guarantee of payment as stated by my insurance company.

I authorize payment of my insurance benefits to Eye Care & Surgery, P.C.

We will file all insurance forms if Eye Care & Surgery, P.C. is a participating provider for your plan.

We will supply you with an itemized statement which you may submit to you insurance carrier.

PAYMENT IN FULL IS REQUIRED AT TIME OF SERVICE.

_____ _____

Signature of patient or legal guardian Today's Date

_____ _____

Provider Signature Date