EYECARE PARTNERS P.C.: CONFIDENTIAL PATIENT INFORMATION

Today's Date________________ (please circle a selection from listed options when applicable) Mr. Mrs. Ms.

First Name __________________________ Middle Initial_____ Last Name_________________________

Preferred Name_______________________ Sex (circle) M F Date of Birth_______________

Address_____________________________ City_________________ State ____ Zip____________

Home Phone__________________________ Work Phone ___________ Cell Phone _________________

E-mail ________________________ May we contact you: via email? **YES/NO** via text message? **YES/NO**

Employer____________________________ Occupation____

Ethnicity: Latino Hispanic Other Preferred Language: English Spanish or ________________
Race: White African American Asian Other

How did you learn about **EyeCare Partners**? Website Facebook Radio Welcome Wagon Personal Referral

If you were referred to our office, who may we thank for referring you?_______________________________

INSURANCE INFORMATION

EyeCare Partners, P.C. participates with several insurance companies. Please provide us with a copy of your insurance card. Any reimbursement you receive from an insurance company depends upon the terms your plan has with that insurance company, not on the fee for services and materials provided by this office. Any insurance payment received by this office on an already paid account will be reimbursed to you.

Insurance Name: ___________________________ **Cardholder's Name:** ________________________

Insurance Number: _________________________ **DOB:** ___________

Plan Name: _______________________________ **Dependent's Name:** ________________________

Plan Number: _____________________________ **DOB**: ___________

Insurance Authorization

I give permission for doctors and employees at EyeCare Partners, P.C. to release to any health care administration (i.e. Blue Cross or Medicare) any medical information about me needed for this insurance claim. I permit a copy of this authorization to be used in place of the original. I request payment of medical insurance benefits be paid to myself or to the party who accepts assignment.

Signature:____ Date: ______________________

Please list who is responsible for patient's account:_______________________________________

Privacy Policy Notice

I acknowledge that I have reviewed and/or received a copy of the Notice of Privacy Practices for EyeCare Partners, P.C.

Signature:____ Date: ______________________

Review of Systems

Date_____________________ Signature____

Date_____________________ Signature____

Date_____________________ Signature____

Ocular History/ Eye Health

Your Eye Health History:

- Glaucoma ☐
- Cataract ☐
- Macular Degeneration ☐
- Eye Surgery ☐
- Inflammatory Disorder ☐
- Retinal Detachment ☐
- Eye Injury ☐
- Lazy Eye ☐

Family History: Father/Mother/etc.

- Glaucoma ☐
- Cataract ☐
- Macular Degeneration ☐
- Eye Surgery ☐

Medical History

Gastrointestinal ☐ **No**

- ☐ Chron's
- ☐ Colitis
- ☐ Ulcer
- ☐ Digestive
- ☐ Other____________________________

Constitutional ☐ **No**

- ☐ Developmental Disability
- ☐ Weight loss
- ☐ Fever
- ☐ Fatigue
- ☐ Trauma
- ☐ Other______________________________

Psychiatric ☐ **No**

- ☐ Depression
- ☐ Panic Disorder
- ☐ Schizophrenia
- ☐ Other___________________________________

Hematoligic/Lymphatic ☐ **No**

- ☐ Anemia
- ☐ Large volume blood loss
- ☐ Leukemia
- ☐ Other_________________________

Endocrine ☐ **No**

- ☐ Non-insulin dependent diabetes
- ☐ Insulin dependent diabetes
- ☐ Thyroid dysfunction
- ☐ Hormonal dysfunction
- ☐ Other__________________________

Musculoskeletal ☐ **No**

- ☐ Fibromyalgia
- ☐ Muscular dystrophy
- ☐ Osteoarthritis
- ☐ Ankylosring spondylitis
- ☐ Other_______________________________

Allergic/Immunologic ☐ No

- ☐ Drug allergy_________________________
- ☐ Environmental allergy
- ☐ Reumatoid arthritis
- ☐ Lupus
- ☐ Other______________________________

Neurological ☐ **No**

- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Alzheimers
- ☐ Parkinsons
- ☐ Cerebrovascular
- ☐ Other_____________________________

Genitourinary ☐ **No**

- ☐ STD, viral herpetic, chlamydia
- ☐ Other_____________________________

Cancer__________________________ ☐ **No**

Ear, Nose, Mouth and Throat ☐ **No**

- ☐ Upper Resp. Tract Infection
- ☐ Ear ache
- ☐ Runny nose
- ☐ Sore throat
- ☐ Ringing/Tinitis Other____________________

Respiratory ☐ **No**

Smoker: Yes No

- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema ☐ Other_______________________

Integumentary ☐ **No**

- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis ☐ Other______________________________

Cardiovascular ☐ **No**

- ☐ Heart disease ☐ Cholesterol
- ☐ High blood pressure ☐ Stroke
- ☐ Vascular disease
- ☐ Other_________________________________

Height________________ **Weight**________________

Medications:

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Pharmacy:____

Physician:____