Welcome to Our Office

Name_____ Today's date_____

Address_____City_____State_____Zip _____

Home Phone_____Cell Phone_____

Social Security Number_____ Date of Birth_____

Employer_____Occupation_____ _____

Email_____ _____

Insurance

Insurance Company Name (Medical)_____

Insurance ID number (Medical) _____

Insurance Group ID (Medical)_____

Vision Company Name_____

Vision Company ID_____

Insured Name_____

Date of Birth_____Last 4 digit SSN_____

Current Medication:
(list all medication taken daily include vitamins)

Past Eye History:

Eye Surgery:_____ Eye Injury:_____

Eye Disease:_____

Social History:

Do you drive?

Do you smoke?

Do you smoke illegal drugs?

Do you drink alcohol?

Height_____Weight_____

Family Medical History

Glaucoma:

Diabetes:

Macular Degeneration:

Name of Physician:
(Please list Office Name)

Pharmacy & Location:

(Please List Year of Diagnosis)

Cardiovascular:

Heart disease_____

High Blood Pressure_____

Stroke_____

Respiratory:

Asthma_____

Emphysema_____

Other_____

Gastrointestinal:

Ulcer_____

Crohns_____

Other_____

Genitourinary:

Sexually Transmitted Disease_____

Musculoskeletal:

Osteoarthritis_____

Fibromyalgia_____

Other_____

Integumentary:

Ecxema_____

Rosacea_____

Psoriasis_____

Other_____

Neurologic/Psychiatric:

Multiple Sclerosis_____

Depression_____

Other_____

Endocrine:

Diabetes_____

Thyroid_____

Hematological:

Anemia_____

Severe Blood Loss_____

Other_____

Allergic: (Please List What You Are Allergic To)

Drug Allergy_____

Environmental_____

Rheumatoid Arthritis_____

Are You Pregnant? YES NO

Disclosure of Personal Health Information:

Eye Care Associates will not discuss your personal health information with anyone

except those allowed under federal and state law without your authorization. This form is good for a lifetime or until change is requested and a new form filled out.

Please list the names and relationships of those you authorize us to disclosure your personal health information.

Contact Names: Relationship: Phone Number:

_____ _____
_____

_____ _____
_____

_____ _____
_____

Patient/Guardian
Signature:_____Date:_____

Financial Agreement:

Payment is due in full when services are received.
I fully understand that I am ultimately responsible for any and all charges associated with my account. This also includes **deductibles, co-payments, and any charges that insurance may not cover if any insurance is filed on my behalf.** If I fail to pay any amount due, I will also be responsible for all collection fees, court cost, attorney fees and any other charges incurred in the collection of any balance due.

Signature:_____Date_____
_____

HIPPA INFO RECIEVED INITALS:_____