□ Stereo ____/____ □ NOTES _____
□ Color ____/____ □ BS _____
□ IOP ____/____ □ BP _____/_____

DOCTOR'S EYE CENTER, PA

□ Appt Time _____
□ NP □ PP VSP DAVIS SPECTERA
□ EE □ CL □ MED □ PATH
□ INS/COPAY_____

Welcome to our practice and thank you for coming in today! Please take a few minutes to fill out the forms as best as you can. If you have any questions we'll gladly assist you. We look forward to managing your eye health.

PATIENT INFORMATION	
NAME: □Mr □ Miss □ Mrs □ Ms □ Dr □ Jr □ Sr	**Date of Birth:**
ADDRESS:	
CITY:	**STATE & ZIP:**
HOME NUMBER:	**CELL NUMBER:**
EMPLOYER:	**WORK NUMBER:**
OCCUPATION:	**SOCIAL SECURITY NUMBER:**
EMAIL:	
SCHOOL:	
MARITAL STATUS: □ SINGLE □ MARRIED □ DIVORCED □OTHER _____	**GENDER:** □ MALE □ FEMALE
RACE: □ WHITE □ AFRICAN AMERICAN □ HISPANIC □ ASIAN □ OTHER_____	**LANGUAGE:** □ ENGLISH □ SPANISH □ OTHER _____

PARENT/LEGAL GUARDIAN INFORMATION	
NAME:	**Date of Birth:**
ADDRESS (if different from patient):	
CITY:	**STATE & ZIP:**
HOME NUMBER:	**CELL NUMBER:**
OCCUPATION:	**SOCIAL SECURITY NUMBER:**
RELATIONSHIP TO PATIENT: □ PARENT □ SPOUSE □ LEGAL GUARDIAN □ POWER OF ATTORNEY □ RELATIVE _____	

INSURANCE INFORMATION	
VISION INSURANCE:	**CARD HOLDER:**
ID NUMBER/SS#:	**CARD HOLDER DATE OF BIRTH:**
MEDICAL INSURANCE:	**CARD HOLDER:**
ID NUMBER/SS#::	**CARD HOLDER DATE OF BIRTH:**

PRIMARY DOCTOR	
PRIMARY PHYSICIAN:	**LOCATION:**

SEE OTHER SIDE

SEE OTHER SIDE

□ Stereo ____/____ □ NOTES _____
□ Color ____/____ □ BS _____
□ IOP ____/____ □ BP _____/_____

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AUTHORIZATION & CONSENT

HOW DID YOU HEAR ABOUT US??

□ SPOUSE □ CHILD □ FAMILY MEMBER □ FRIEND □ PHONEBOOK □ DOCTOR/OFFICE _____ □ OTHER _____

AUTHORIZATION

I have reviewed the information on these forms and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to determine the appropriate treatment. I will inform the doctor of any change in my medical status. I authorize the use of this signature on all insurance submissions. I authorize my insurance to pay Doctor's Eye Center, PA all insurance benefits otherwise payable to me for services rendered. I authorize the doctor to release all information necessary to secure payment. I understand that I am financially responsible for all charges whether or not paid by my insurance. Failure to resolve my financial responsibilities will result in collections or dismissal from our practice.

Signature _____ **Date** _____

RELEASE OF INFORMATION

PATIENT NAME:	**DATE OF BIRTH:**

Doctor's Eye Center, PA is authorized to release Protected Health Information about the above named patient to the entities listed below. The purpose of this, is to inform the patient or others in keeping with the patient's information.

ENTITIES ALLOWED TO RECEIVE INFORMATION	**INFORMATION ALLOWED TO BE RELEASED**
□ VOICEMAIL AND □ POSTCARD/MAIL	□ APPOINTMENT INFORMATION □ OTHER _____
□ PARENT **NAME:** _____	□ APPOINTMENT INFORMATION □ OTHER _____ □ FINANCIAL INFORMATION
□ SPOUSE **NAME:** _____	□ APPOINTMENT INFORMATION □ OTHER _____ □ FINANCIAL INFORMATION
□ CHILD **NAME:** _____	□ APPOINTMENT INFORMATION □ OTHER _____ □ FINANCIAL INFORMATION
□ LEGAL GUARDIAN OR CARE GIVER **NAME:** _____	□ APPOINTMENT INFORMATION □ OTHER _____ □ FINANCIAL INFORMATION
□ OTHER **NAME:** _____	□ APPOINTMENT INFORMATION □ OTHER _____ □ FINANCIAL INFORMATION

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect the information released. I understand that I can not revoke information that has already been disclosed, but will be effective going forward.
I understand that I have the right to refuse to sign this authorization and that my treatment will not be effected on signing. I understand that information used or disclosed as a result of this authorization may be subject to disclosure by the recipient and may no longer be protected by the federal or state law. This authorization is in effect until revoked by the patient.

Signature _____ **Date** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

By signing below, I state that I have reviewed a copy the Notice of Privacy Practices (attached to clipboard). I am aware that I can receive a copy of Notice of Privacy Practices, at my request.

NAME:	□ PATIENT □ SPOUSE □ CHILD □ GUARDIAN/CARE GIVER □ OTHER _____

Signature _____ **Date** _____

CONSENT FOR TREATMENT

I understand the type and extent of services will be determined following initial evaluation and thorough discussion with me. The goal of the evaluation process is to determine the best course of treatment for me/ the patient. I hereby consent to medical treatment for myself or the patient whom I am the parent or legal authorized representative.

Signature _____ **Date** _____

SEE OTHER SIDE

SEE OTHER SIDE

□ Stereo ____/____ □ NOTES _____
□ Color ____/____ □ BS _____
□ IOP ____/____ □ BP _____/_____

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PATIENT MEDICAL HISTORY

ALLERGIES

□ MEDICATIONS _____

□ FOODS _____

□ LATEX □ ADHESIVES (BANDAIDS, TAPE) □ NONE

CURRENT MEDICATIONS

MEDICINE NAME (OR PROVIDE LIST)	DOSE	HOW OFTEN DO YOU TAKE IT?

SURGERIES (List type and year)

_____

_____

_____

_____

_____

PHARMACY INFORMATION

PHARMACY NAME & ADDRESS:	PHONE NUMBER:

SOCIAL HISTORY

What is your Tobacco use?

□ CURRENTLY □ FORMERLY □ NEVER **TYPE:** □ CIGARETTES □ PIPE □ CHEWING □ CIGAR □ SMOKELESS

DAILY AMOUNT: _____ (Packs, ounces, cigars, etc) **YEARS:** _____ **PASSIVE SMOKE EXPOSURE** □ YES □ NO

OTHER SUBSTANCES? _____

What is your alcohol use?

DO YOU DRINK ALCOHOL: □ YES □ NO **FREQUENCY:** □ DAILY □ WEEKLY □ MONHTLY □ OCCASSIONALLY □ RARELY

DO YOU DRINK CAFFEINE? □ YES □ NO **HOW OFTEN?** _____

EMERGENCY CONTACT INFORMATION

LAST NAME:	FIRST NAME:
ADDRESS:	
CITY:	STATE & ZIP:
HOME NUMBER:	CELL NUMBER:

RELATIONSHIP: □ SPOUSE □ PARENT □ CAREGIVER □ LEGAL GUARDIAN □ FRIEND □ RELATIVE

SEE OTHER SIDE

SEE OTHER SIDE

□ Stereo ____/____ □ NOTES _____
□ Color ____/____ □ BS _____
□ IOP ____/____ □ BP _____/_____

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PATIENT MEDICAL HISTORY

PATIENT NAME:	**DATE OF BIRTH:** **AGE:**
PRIMARY DOCTOR:	**GENDER:** □ MALE □ FEMALE

PATIENT EYE HISTORY

CHECK THOSE THAT APPLY: □ **RIGHT** □ **LEFT** □ **BOTH**

□ REDNESS □ FLASHES □ DRYNESS □ ITCHING □ LAZY EYE □ FLOATERS □ BLURINESS □ BURNING □ WATERING

□ DOUBLE VISION □ SWELLING □ GLARE □ HALOS □ GLAUCOMA □ MACULAR DEGENERATION □ CATARACTS

□ LOSS OF VISION □ LIGHT SENSITIVITY □ **EYE INJURY** _____ □ **EYE SURGERY** _____

GLASSES AND CONTACT HISTORY

GLASSES: □ FULLTIME □ COMPUTER/NEAR/READING □ DISTANCE □ NONE
HOW OLD IS YOUR CURRENT GLASSES? _____ **PREVIOUS EYE DOCTOR** _____ **YEAR** _____
CURRENT ISSUES WITH GLASSES: □ READING □ DISTANCE □ BLURRINESS □ OTHER _____

CONTACTS: □ MONTHLY □ WEEKLY □ DAILY **BRAND:** _____
HOW OFTEN DO YOU SLEEP IN THEM? _____ **HOW OFTEN DO YOU CHANGE THEM?** _____
HOW OLD IS YOUR CURRENT PAIR OF CONTACTS? _____
ARE YOU CURRENT CONTACTS COMFORTABLE? □ YES □ NO **WOULD YOU LIKE TO TRY COLORS?** □ YES □ NO
HOW OFTEN WOULD YOU PREFER TO SWITCH OUT YOUR CONTACTS? □ MONTHLY □ WEEKLY □ DAILY

PATIENT MEDICAL HISTORY

CHECK THOSE THAT APPLY: □ **BLOOD PRESSURE** _____/_____ □ **A1C** _____ □ **BLOOD SUGAR** _____

□ HIGH BLOOD PRESSURE **IS IT CONTROLLED?** □ YES □ NO

□ DIABETES **TYPE?** □ TYPE I □ TYPE II **IS IT CONTROLLED?** □ YES □ NO **# OF YEARS?** _____ □ INSULIN □ PILL □ DIET

□ HEART ATTACK □ HEART FAILURE □ HEART SURGERY □ HEART DISEASE □ HIGH CHOLESTEROL □ PACE MAKER

□ CHEST PAIN □ ARRHYTHMIA □ STROKE **WHEN:** _____ **DEFECTS:** _____ □ SEIZURES □EPILEPSY

□ ANEMIA □ BLEEDING DISORDER □ PNEUMONIA □ ASTHMA/EMPHYSEMA □ BRONCHITIS

□ FEVER/WEIGHT LOSS □ BIRTH CONTROL □ PREGNANT **HOW FAR ALONG?** _____

□ SICKLE CELL TRAIT □ KIDNEY DISEASE □ KIDNEY FAILURE/DIALYSIS □ CIRRHOSIS □ HEPATITIS TYPE _____

□ HIV □ STD TYPE _____ □ TUBERCULOSIS/TB **WHEN TREATED?** _____

□ BACK PROBLEMS □ ARTHRITIS □ HEADACHES □ MIGRAINES □ ANXIETY □ DEPRESSION □ PSYCHIATRIC TREATMENT

□ STOMACH PROBLEMS □ CANCER **TYPE?** _____ □ PARKINSONS □ MS
□ **OTHER CONDITIONS NOT LISTED** _____

FAMILY MEDICAL HISTORY

□ HEART DISEASE □ HIGH BLOOD PRESSURE □ DIABETES

□ GLAUCOMA □ CATARACTS □ MACULAR DEGENERTAION □ BLINDNESS □ LAZY EYE □ RETINAL DETACHMENT

□ OTHER _____

SEE OTHER SIDE

SEE OTHER SIDE

□ Stereo ____/____ □ NOTES _____
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