Patient Information (Please Print) **Community Eye Center, P.A.** 10-18-2019

First Name	Last Name			Date	
Address		S.S. No.		Occupation	
City	State	Zip Code	Date of Birth	Age	Male ☐ Female ☐
Home Phone Number	Cell Phone Number			Date of last eye exam	
Email Address		Emergency Contact Name PH#			

What brings you to our office today? *Please check all that apply.*

☐ Routine Eye Exam ☐ Medical Do you want Glasses ___ Contacts ___ Other: _____

Difficulty with:

☐ Driving	☐ Burning Eye(s)	☐ Eye Strain	☐ Headaches
☐ Golfing	☐ Double Vision	☐ Flashes / Floaters	☐ Red Eye(s)
☐ Reading	☐ Eye Infection	☐ Glare	☐ Tearing
☐ Other:			

History of Present Illness: *From above, please explain.*

Location: _____ Severity: _____

Duration: _____ Context / Onset: _____

Timing: _____ Modifying / Relieving Factors: _____

Quality: _____ Associated Signs & Symptoms: _____

Do you currently wear: *Please check all that apply.*

Glasses: ☐ No ☐ Yes Distance ☐ Readers ☐ Lined Multi-focal ☐ Progressive ☐

Contacts: ☐ No ☐ Yes Brand: _____

Eye Health: Do you now or have you ever had? *Please check all that apply.*

☐ Eye Injury	☐ Macular Degeneration	☐ Strabismus (eye turn)
☐ Eye surgery or LASIK	☐ Glaucoma	☐ Vision Therapy
☐ Cataracts	☐ Lazy eye (amblyopia)	☐ Keratoconus
☐ Other:		

PFSH - Family History / Relationship to patient: [M]other, [F]ather, [G]randparent, [S]ibling *Please check all that apply.*

☐ Cataract	M	F	G	S	☐ High Blood Pressure	M	F	G	S
☐ Glaucoma	M	F	G	S	☐ Heart Attack(s) / Disease	M	F	G	S
☐ Macular Degeneration	M	F	G	S	☐ Cancer: (type & location)	M	F	G	S
☐ Retinal Detachment	M	F	G	S	☐ Kidney Disease	M	F	G	S
☐ Diabetes	M	F	G	S	☐ Stroke(s)	M	F	G	S
☐ Strabismus / Muscle Problems	M	F	G	S	☐ Arthritis	M	F	G	S
☐ Hereditary Eye Disease	M	F	G	S	☐ Thyroid Disease	M	F	G	S
☐ Other:									

Medication(s): *Please provide your list of prescriptions & over-the-counter medications you are taking and preferred pharmacy.*

Are you allergic to any medications? ☐ No ☐ Yes If yes, please list with reaction(s): _____

Have you received the: Influenza (Flu) vaccine: ☐ No ☐ Yes Pneumonia vaccine: ☐ No ☐ Yes

Social History: *Please mark all that apply.*

Do you smoke / vape? ☐ No ☐ Yes Alcohol Use: ☐ No ☐ Yes Drug Use: ☐ No ☐ Yes

Do you have a Living Will? ☐ No ☐ Yes

Insurance: 10-18-2019

Vision: ☐ No ☐ Yes Insurance Name: _____

Insured's Name: _____ Insured's Date of Birth: _____
Insured Member ID #: _____ Relationship to Insured: _____
Insured's Employer: _____

Medical:
Primary: ☐ No ☐ Yes Insurance Name: _____

Insured's Name: _____ Insured's Date of Birth: _____
Insured Member ID #: _____ Relationship to Insured: _____
Insured's Group Number: _____

Secondary: ☐ No ☐ Yes Insurance Name: _____

Insured's Name: _____ Insured's Date of Birth: _____
Insured Member ID #: _____ Relationship to Insured: _____
Insured's Group Number: _____

if applicable:
Workers' Compensation: ☐ No ☐ Yes Insurance Name: _____

Patient's Employer: _____ Case Manager Name: _____
Employer Phone No.: _____ Case Manager Phone No.: _____

if applicable:
Auto Accident Insurance: ☐ No ☐ Yes Insurance Name: _____

Insured's Name: _____ Insured's Date of Birth: _____
Insured Member ID #: _____ Relationship to Insured: _____
Insured's Group Number: _____

Acknowledgements

Patient Notification - Consent to Treatment

Please be advised that if you are being seen today for a Routine Eye Exam that based upon any of the following concerns: family history, current medical disease and/or conditions, chief complaint or pre-test findings the Doctor may find it necessary to bill your exam medically as well as order additional tests. You will be notified during the course of the exam if medical billing is necessary. Exams billed medically are not covered under your Routine Eye Exam benefits or Vision Insurance Plan.

If a medical issue exists, your exam will be billed medically through your Medical Insurance Carrier and you are subject to their specific co-pays, deductibles and co-insurances which will be due at the time of service. In the event you want a Routine Eye Exam for your eyeglasses or contact lens prescription only, you understand it is your responsibility to immediately inform the Doctor and medical complaints or findings will be addressed at a separate visit.

Financial Acknowledgement

The patient is responsible for providing Community Eye Center, P.A. with accurate and complete information concerning primary and secondary insurance medical benefits, including referral documents from other providers. Current identification and insurance benefit cards are to be presented at each office visit. As a courtesy, Community Eye Center, P.A. will file your insurance claim for you. If you are a Medicare patient, we will bill Medicare and your secondary insurance for you. Your signature authorizes payment to be made on your behalf to Community Eye Center, P.A. for any services provided to you by your provider. Your signature also authorizes the provider to release to your insurance and its agents any information needed to determine your benefits. Your signature also authorizes the release of benefits payable from your secondary insurance and any medical information necessary to be released to that secondary insurance payer.

Consent of Acknowledgements

I have read the "Consent To Treatment" and "Financial Acknowledgement" as the Patient, the patient's Authorized Representative / Guardian, or general Agent for the purpose of signing this document and hereby accepts its terms.

Patient Name (please print): _____
Patient / Guardian Signature: _____ Date: _____

Patient Name: | Are you pregnant / nursing? ☐ No ☐ Yes

Primary Care Physician:

Review of Systems: *Please explain all checked boxes on the back side of this page.*

Ears, Nose, Mouth, Throat
- ☐ Hearing Problems
- ☐ Sinus Problems
- ☐ Throat or Mouth Problems

Cardiovascular - Heart
- ☐ Atrial Fibrillation
- ☐ Abdominal Aortic Aneurysm
- ☐ Angina (chest pain / discomfort)
- ☐ Arrhythmia - Irregular Heartbeat
- ☐ Blood Clots (DVT) Deep Vein Thrombosis
- ☐ Carotid Artery Disease
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Heart Murmur
- ☐ Heart Valve Disease
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Hypotension
- ☐ Myocardial Infarction - Heart Attack
- ☐ Rheumatic Fever

Respiratory - Breathing
- ☐ Asthma
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Chronic Cough
- ☐ COPD
- ☐ Shortness of Breath
- ☐ Sleep Apnea
  - ☐ CPAP w/ Oxygen
  - ☐ CPAP w/o Oxygen
- ☐ Tuberculosis

Gastrointestinal Disease - Stomach
- ☐ Acid Reflex - Heartburn
- ☐ Colitis - Ulcerative / Crohn's disease
- ☐ Diverticulitis / Diverticulosis
- ☐ Gastric Stomach Ulcer
- ☐ Hiatal Hernia
- ☐ Irritable Bowel Syndrome (IBS)

Genitourinary
- ☐ Bladder Incontinence
- ☐ Chronic Dialysis
- ☐ Cystitis - (UTI) Urinary Tract Infection
- ☐ Enlarged Prostate
- ☐ Kidney Stones
- ☐ Renal Insufficiency
- ☐ Renal Failure
- ☐ Uterine Disease

Integumentary Disease (Skin)
- ☐ Eczema
- ☐ Psoriasis

Musculoskeletal (muscles, joints, bones)
- ☐ Arthritis
- ☐ Arthritis (Rheumatoid)
- ☐ Gout
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Polymyalgia

Neurological
- ☐ ADHD / ADD
- ☐ Alzheimer's
- ☐ Anxiety
- ☐ Cerebral Palsy
- ☐ Dementia
- ☐ Depression
- ☐ Down Syndrome
- ☐ Fibromyalgia
- ☐ Mini Strokes (TIA)
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Neuropathy
- ☐ Parkinson's
- ☐ Polio
- ☐ Psychiatric Disorder
- ☐ Seizure Disorder
- ☐ Speeech Delay
- ☐ Stroke (CVA)

Hematologic / Lymphatic (Blood)
- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Blood Transfusions
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Malignant Hyperthermia

Endocrine
- ☐ Diabetes Mellitus, type 1 (insulin)
- ☐ Diabetes Mellitus, type 2 (diet controlled)
- ☐ Diabetes Mellitus, type 2 (oral meds)
- ☐ Diabetes Mellitus, type 2 (insulin)
- ☐ Thyroid Disease
  - ☐ Hyperthyroidism
  - ☐ Hypothyroidism
  - ☐ Other: _____

Allergic / Immunologic
- ☐ AIDS / HIV
- ☐ Allergies to:
  - ☐ Medications
  - ☐ Environmental
  - ☐ Seasonal
  - ☐ Food
  - ☐ Latex
- ☐ Lupus Erythematosus
- ☐ Myasthenia Gravis

Cancer
- ☐ Bladder
- ☐ Breast
- ☐ Colon
- ☐ Hodgkin's
- ☐ Leukemia
- ☐ Lung
- ☐ Lymphoma
- ☐ Non-Hodgkin's
- ☐ Ovarian
- ☐ Prostate
- ☐ Skin
  - ☐ Basal Cell
  - ☐ Melanoma
  - ☐ Squamous Cell
- ☐ Thyroid
- ☐ Uterine
- ☐ Other: _____

History of Infectious Disease
- ☐ Chicken Pox
- ☐ Herpes Zoster - Shingles
  - ☐ Shingles Vaccine
- ☐ MRSA
- ☐ Meningitis

Genetic Disorders
- ☐ Chromosome Abnormality
- ☐ Syndrome or identified genetic disease
- ☐ Retinitis pigmentosa
- ☐ Color blindness
- ☐ Other: _____

Please list any other health condition(s) or surgeries you may have or had that has not been listed: _____

Have you been explosed to: ☐ Gonorrhea ☐ Hepatitis ☐ Syphilis ☐ Tuberculosis (TB)