ALL ABOUT EYECARE, P.C.
WELCOME TO OUR OFFICE
Ruth Scholten-Lellbach, OD and Rebekah Bretz, OD

LAST NAME _____FIRST_____ MI_____NICKNAME _____

DOB_____SSN_____ REFERRED BY_____ OCCUP_____

ADDRESS_____CITY_____ZIP_____

PHONE(H)_____(W)_____(C)_____EMAIL_____

PREFERENCE OF NOTIFCATION(circle one) Phone Cell Text Mail

EMERGENCY CONTACT PERSON: _____Phone _____Relation:_____

INSURANCE INFORMATION

RESPONSIBLE PARTY: SELF/SPOUSE/PARENT
NAME_____PHONE_____SSN_____DOB_____
EMPLOYER_____VISION INS _____ MEDICAL INS_____

Race: White African American Asian Hispanic/Latino Native American

Ethnicity: Not Hispanic or Latino Hispanic or Latino Native Hawaiian/Other Pacific Islander

EYE HEALTH HISTORY

LAST EYE EXAM_____ CHIEF COMPLAINT TODAY_____

GLASSES	Y N	INJURIES	Y N	LAZY EYE	Y N
CONTACTS	Y N	GLAUCOMA	Y N	INTEREST IN LASIK SURGERY?	Y N
SURGERY	Y N	CATARACTS	Y N	DO YOU USE THE COMPUTER?	Y N____#HRS
DRY EYES	Y N	EYE ALLERGIES	Y N	INTERESTED IN CONTACTS?	Y N

PATIENT MEDICAL HISTORY/ IF SO, DESCRIBE **NAME OF PCP:_____**

EARS/NOSE/THROAT	Y N	_____	DIABETIC	Y N	Year Diagnosed_____
GASTROINTESTINAL	Y N	_____	HYPERTENSION	Y N	Year Diagnosed_____
PHYCHOLOGICAL	Y N	_____	HIGH CHOLESTEROL	Y N	
NEUROLOGICAL	Y N	_____	MEDICATIONS	Y N	
CARDIOVASCULAR	Y N	_____	if so, please list_____		
MUSCULOSKELETAL	Y N	_____	_____		
BLOOD/LYMPH	Y N	_____	_____		
RESPRIRATORY	Y N	_____	ALLERGIC TO ANY MEDICATIONS?	Y N	
SKIN	Y N	_____	if so, please list_____		
ALLERGY/IMMUNE	Y N	_____	_____		
TOBACCO USE	Never Smoker	Current Smoker	Former Smoker		
ALCOHOL USE	Y N	_____			

FAMILY HISTORY

HYPERTENSION	Y N	who?_____	MACULAR DEGENERATION	Y N	who? _____
DIABETES	Y N	who?_____	RETINAL DETACHMENT	Y N	who? _____
CANCER	Y N	who?_____	CATARACT	Y N	who? _____
HIGH CHOLESTEROL	Y N	who?_____	GLAUCOMA	Y N	who? _____

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned have insurance coverage with_____, and assign directly to All About Eyecare, P.C. all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance carrier. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I understand that this office will bill my insurance for me as a courtesy, and I am aware that I am responsible for any balance not covered by my insurance carrier.

SIGNED_____DATE_____