ALL ABOUT EYECARE, P.C.-*Vision Source*

WELCOME TO OUR OFFICE

Ruth Scholten-Lellbach, OD

Last Name________________ First________________ MI______ Nickname________________

DOB____________ SSN________________ How did you hear about our office?________________

Address________________ City________________ ZIP____________ Occup____________

Phone(H)________________ (W)________________ (C)________________ EMAIL________________

Preference of Notification (circle one) Phone Cell Text Mail

Emergency Contact: ________________ Phone ________________ Relation: ____________

INSURANCE INFORMATION

Responsible Party: (circle one) 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________________