ALL ABOUT EYECARE, PC-Vision Source

Welcome To Our Office!

Ruth Scholten-Lellbach, OD and Rebekah Bretz, OD

Last Name_____First_____MI___Nickname_____

DOB_____ SSN_____ How did you hear about our office?_____

Address_____City_____Zip_____Occup_____

Phone(H)_____Cell_____Work_____Email_____

Preference of Notification (circle one) home cell work email

Race: white African American Asian Hispanic/Latino Native American Other

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

Emergency Contact:_____Phone_____Relation_____

I**nsurance Information**:

Responsible Party: Name_____ (circle one) self spouse parent

Phone_____SSN_____DOB_____Employer_____
Vison benefit_____ Medical Insurance_____

Eye Health History

Last Eye Exam_____ Reason for coming in today_____

Glasses	Y N	Injuries	Y N	Eye Allergies	Y N
Contacts	Y N	Glaucoma	Y N	Interested in Lasik	Y N
Surgery	Y N	Cataracts	Y N	Interested in contacts	Y N
Dry Eyes	Y N	Lazy Eye	Y N	Hours on computer/device per day	_____

Patient Medical History

Ears/Nose/Throat	Y N _____	Diabetes	Y N _____yr diagnosed
Gastrointestinal	Y N _____	Hypertension	Y N _____yr diagnosed
Psychological	Y N _____	High Cholesterol	Y N _____yr diagnosed
Neurological	Y N _____	Medications	_____
Cardiovascular	Y N _____		_____
Muscular-Skeletal	Y N_____		_____
Blood/Lymph	Y N _____	Allergic to Medications	Y N if so please list

Respiratory	Y N _____	_____	
Skin	Y N _____	Tobacco Use: Never Former Current	
Allergic/Immune	Y N _____	Alcohol Use: Y N	Marijuana Use Y N

Family Medical History

Hypertension	Y N who_____	Macular Degeneration	Y N who_____
Diabetes	Y N who_____	Glaucoma	Y N who_____
Cancer	Y N who_____	Cataract	Y N who_____
High Cholesterol	Y N who_____	Retinal Detachment	Y N who_____

Assignment of Insurance Benefits:

I, the undersigned, have insurance coverage with _____, and assign directly to All About Eyecare 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 by insurance as a courtesy and I am aware that I am responsible for any balance not covered by my insurance carrier.

Signed _____ Date_____