

ALL ABOUT EYECARE, PC-Vision Source, Welcome To Our Office!

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: (circle one) white African American Asian Hispanic/Latino Native American Other
Ethnicity: (circle one) Not Hispanic or Latino Hispanic/Latino Native Hawaiian/Pacific Islander Other

Emergency Contact: _____ Phone _____ Relation _____

May we leave a message, which may have personal medical information on you home and/or cell phone? Y N

If so, which one, please circle cell / home / both

Insurance Information:

Responsible / Insured: Name _____ (circle one) self spouse parent
Phone _____ SSN _____ DOB _____ Vision benefit _____
Medical Insurance _____ Subscriber/Member ID# _____ Group ID# _____

Eye Health History

Last Eye Exam _____ Reason for coming in today _____
Glasses Y N Injuries Y N Surgery Y N what _____
Contacts Y N Glaucoma Y N Interested in Lasik Y N
Cataracts Y N Eye Allergies 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 | _____ | Alcohol Use: | Y N | Marijuana Use Y N | |
| Allergic/Immune | Y N | _____ | Tobacco Use: | Never | Former | Current |
| Endocrine | Y N | _____ | | | | |

1. Do you have to strain to understand what people say? Y N
2. Do you have trouble hearing in a noisy place like a restaurant? Y N
3. How would you rate your hearing on a scale of 1 to 10? _____

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, _____, hereby assign and request that payment of all medical and vision benefits be made to ALL ABOUT EYECARE, PC. I authorize the release of all medical and other information that is necessary to process claims. I understand that I am financially responsible for any and all non-covered charges incurred while under the care of said office, including co-payments. It is also acknowledged that any unpaid balances may be subject to collections and is the responsibility of the guarantor.

Signed _____ Date _____