



EYECARE ASSOCIATES, P.C.

Patient's Name: First _____ Middle Initial _____ Last _____

Permanent Address _____ City _____ State _____ Zip _____

Date of Birth ___/___/___ Sex: M F Social Security # _____

Race: American Indian or Alaska Native	Ethnicity: Hispanic
Asian	Native American/Other Pacific Islander
Black or African American	Not Hispanic or Latino
Hispanic	Communication Preference: Email Postal Telephone
Native Hawaiian/Other Pacific Islander	Preferred Language: English
White	Spanish

If Minor, Name of Guardian _____ If Married, Spouse's Name _____

Daytime (Primary) Phone _____ Home Phone _____

Employer _____ Occupation _____

In the event of an emergency whom can we contact? _____ Phone _____

Whom May We Thank for Referring You to Our Office:	Yellow Book	Search Engine	Insurance Listing
Patient: _____	Dex	Other: _____	



VISION HISTORY

Have you, or has your family, had any history of eye problems in the following areas?

	Self	Family		Self	Family
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetic Eye Disease	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Keratoconus	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Eye Surgeries	<input type="checkbox"/>	<input type="checkbox"/>
Eye Turns	<input type="checkbox"/>	<input type="checkbox"/>	Eye Allergies	<input type="checkbox"/>	
Retinal Detachments	<input type="checkbox"/>	<input type="checkbox"/>	Eye Injuries	<input type="checkbox"/>	
Amblyopia (Lazy Eye)	<input type="checkbox"/>	<input type="checkbox"/>	Eye Infections	<input type="checkbox"/>	

Please describe any conditions marked above: _____

Who was your previous eye doctor? _____ Date of your last eye exam? _____

Are you currently wearing: Glasses _____ Contacts _____ Any concerns: _____

HEALTH HISTORY

Do you have, or does your family have, any medical history of problems in any of the following areas?

	Self	Family		Self	Family
Digestive System	<input type="checkbox"/>	<input type="checkbox"/>	Nervous System (headache, MS, seizures, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory (asthma, emphysema, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Ear / Nose / Throat	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary (kidney, bladder, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Allergies / Immune system	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular (cholesterol, high blood pressure, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Mental / Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine (thyroid, diabetes, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Blood / Lymph	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal (arthritis, joint pain, etc.)	<input type="checkbox"/>	<input type="checkbox"/>

Height _____ Weight _____ Are you a Current Smoker/Previous Smoker/Never Smoked

Please describe any conditions marked above: _____

Please list any medications you are taking: _____

Are you allergic to any medications? _____

Who is your primary care physician? _____ Other medical doctors? _____

Health Insurance Portability and Accountability Act-HIPAA

We respect the legal obligation to keep your health information private. We are obligated by law to give you notice of our privacy practice. The most common reason why we use or disclose your health information is for treatment, payment, or health care operations. If you would like a copy of our Notice of Privacy Practice please let the front desk know.

By signing below it means that you are aware of your privacy practices and that you have been given the opportunity to obtain a copy of our policy.

Signed: _____ Date: _____

PAYMENT INFORMATION

Payment is expected at the time services are rendered. One-half the cost of materials will be due at the time an order is placed. The balance is due at the time materials are dispensed or picked up. Accounts left unpaid after 60 days will automatically be turned over for collections assistance. At this time, a \$35 service charge will be added to the account.

I understand that I will receive a statement after 30 days if the insurance is not paid. I further understand that I am responsible for the total amount due or any amount unpaid by the insurance. Any denial or dispute of payment by my insurance company is my responsibility and not Eyecare Associates. If insurance is being billed by our office, this signature serves as your "signature on file".

Signed: _____ Date: _____

