Welcome

We are pleased to welcome you to Generations Family Eyecare. Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you.

PATIENT INFORMATION Date _____

Full Name _____

Birthdate _____

Street Address _____

City, State Zip _____

Place of employment _____

Occupation/Job Description _____

Social security # _____

Marital status _____Spouse Name_____

RESPONSIBLE PARTY □ Self

Name _____

Address _____

City, State Zip _____

Phone (Home) _____ (Work) _____

Relationship to patient _____

PHONE NUMBERS

Home _____ Work _____

e-mail _____Cell _____

Best time & Place to reach you _____

Emergency contact _____

Home _____ Work _____

INSURANCE INFORMATION

Insurance Co. _____

Member's Name _____

Birthdate _____ ID# _____

Employer _____

Insurance Co. _____

Member's Name _____

Birthdate _____ ID# _____

Employer _____

Insurance Co. _____

Member's Name _____

Birthdate _____ ID# _____

Employer _____

I Authorize this office to release to my insurance carriers, Medicare, Medicaid and Medicare supplements, any information required to file or resubmit my claim. I further authorize all insurance carriers, Medicare, Medicaid and Medicare supplements to pay this office directly on my behalf. I authorize all insurance carriers, Medicare, Medicaid and Medicare supplements to provide any information required to resubmit any denied or incorrectly paid claims. This authorization remains in effect until withdrawn by me.

_____ _____

Patient / Guardian Signature Date

How did you hear about our office?

□ Friend or relative. Who? _____

□ Another doctor. Who? _____

□ Insurance Company or Eye Care Plan

□ Yellow Page Advertisement

Other _____

Visual Needs

Do you work at a computer?	□ Yes □ No
Do you participate in outdoor sports?	□ Yes □ No
Are your eyes sensitive to sunlight?	□ Yes □ No
Is the weight of your glasses bothersome?	□ Yes □ No
Are there times you would rather not wear glasses or contact lenses?	□ Yes □ No

EYE HEALTH HISTORY

Date of last eye exam _____

Name of Doctor _____

Do you wear glasses? □ Yes □ No

□ All the time □ Occasionally

Do you wear contacts? □ Yes □ No

Number of Hours/Day _____

Describe any problems you currently have with your vision

_____

_____

_____

_____

_____

FAMILY HISTORY

Has anyone who is a blood relative had eye trouble other than having to wear glasses? (crossed eyes, diabetic retinopathy, cataracts, glaucoma, retinal detachment, color or night blindness, etc.) ☐ YES ☐ NO

If so, list the disease, person and their relation to yourself: _____

_____

Do any diseases tend to run in your family? (Diabetes, cancer, heart disease, etc.) ☐ YES ☐ NO

If so, list the disease, person and their relation to yourself: _____

_____

MEDICAL HISTORY

List all major illnesses or injuries you have, or have had in the past and when: _____

_____

List any surgeries you have had and when: _____

_____

List your medications and dosages: _____

_____

List any allergies to medications: _____

Do you use any of the following: ☐ Alcohol ☐ Tobacco ☐ Drugs ☐ None

Do you currently have any problems in the following areas? If so, please describe in the lines below.

Eyes	**YES**	**NO**		**YES**	**NO**
Loss of center or side vision	☐	☐	Other Heart problems	☐	☐
Blurred or distorted vision	☐	☐	Stroke	☐	☐
Double vision	☐	☐	High blood pressure	☐	☐
Fluctuating vision	☐	☐	Cancer	☐	☐
Occasional dryness	☐	☐	Blood disorders (Anemia, etc.)	☐	☐
Sandy or gritty feeling	☐	☐	Asthma	☐	☐
Itching or burning	☐	☐	Chronic bronchitis	☐	☐
Excess tearing or watering	☐	☐	Other Breathing Problems	☐	☐
Glare/light sensitivity	☐	☐	Arthritis	☐	☐
Redness	☐	☐	Neurological (epilepsy/seizures)	☐	☐
Eye pain or soreness	☐	☐	Psychiatric (depression, anxiety)	☐	☐
Chronic infection of eye or lid	☐	☐	Diabetes	☐	☐
Sties, Growths, Chalazions	☐	☐	Thyroid	☐	☐
			Immune disorders	☐	☐
Medical			Allergies	☐	☐
Ears, nose, mouth, throat, sinus	☐	☐	Hay fever symptoms	☐	☐
Angina	☐	☐	Headaches	☐	☐
High cholesterol	☐	☐	Fever, weight loss, other	☐	☐

Please provide further details: _____

_____

_____