WELCOME TO OUR OFFICE

Thank you for choosing Allen Eyecare Center for your eye care needs. Please complete this form. If you have questions or concerns, do not hesitate to ask for assistance. We are happy to help.

Today's Date____/____/____

Last Name_____ First Name_____ MI_____
DOB____/____/____ Gender: M☐ F☐ SSN:____-____-____ Preferred Name_____
Address: _____ City: _____
_____ State: _____ ZIP: _____
Primary Phone: (____)_____ Secondary Phone: (____)_____
Email Address: _____
Employer/School: _____
Occupation/School Grade: _____ Spouse's Name: _____

If you are a new patient, whom may we thank for referring you to our office?
Name of friend, relative or doctor: _____
If not referred, how did you choose our office for your needs:
☐Insurance List ☐Yellow Pages ☐Website: _____
☐Twitter ☐Building Seen/Sign ☐Other: _____
☐Facebook

BILLING INFORMATION

Name of person responsible for this account: _____
Relationship to patient: _____ Phone: (____)_____
Address:_____
_____

INSURANCE INFORMATION

Vision Insurance _____ DOB____/____/____
Subscriber's Name _____ Subscriber ID/SSN ____-____-____
Medical Insurance (Primary)_____ ID# _____
Subscriber's Name_____ DOB ____/____/____
Provider or Customer Service Phone # _____

* A copy of your insurance card is required *

I authorize release of any information including the diagnoses and treatment records of any examination rendered to me or my child during the period of such care to third party payers and/or other health care practitioners.

I authorize and request my insurance company to pay benefits directly to the provider.

I understand that my insurance company may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I consent to the treatment of my eyes by the doctors of Allen Eyecare Center.

Signature of patient/responsible party:_____ Date:___/___/__

(OVER)

PATIENT PRIVACY INFORMATION

I, _____, agree that it is permissible to release information about my health to: _____

_____

_____

I, _____, agree that it is permissible to leave a message about my health information on ☐ Answering Machine ☐ Voice Mail

I have read, or was offered and declined to read, a notice of Allen Eyecare's privacy practice.

Signature of patient/responsible party:_____ Date:___/___/__

PATIENT HISTORY

Do you take medications? ☐No ☐Yes (if yes, please provide list) ☐ **NO CHANGES SINCE LAST VISIT**

REASON FOR VISIT (check all that apply): ☐ **Exam** ☐ **Glasses** ☐ **Contacts**

☐ **Eye infection/injury** ☐ **Medical Problem** ☐ **Other**_____

Date of last eye exam: _____/_____/_____ Eye Doctor's Name/Clinic: _____

Do you wear glasses: ☐ All the Time ☐ Occasionally ☐ Office Work ☐ Reading Only ☐ Driving Only ☐ Not At All

Do you currently wear contact lenses? ☐ Yes ☐ No List Brand/Prescription:_____

Do you currently use eye drops: ☐ Yes ☐ No Please List: _____

Do you: (check box if yes)

☐ Work at a computer? (_____hrs/day) ☐ Have computer or reading glasses?

☐ Spend time outdoors? (_____hrs/day) ☐ Have prescription sunglasses?

Do you, or have you ever had:

☐ Diabetes ☐ Hypertension ☐ Glaucoma ☐ Cataracts ☐ Retinal Detachment ☐ Macular Degeneration

☐ Eye Injuries If yes, which eye? _____When? _____

☐ Eye Surgeries If yes, type? _____ Which eye? _____ When? _____

☐ Other Eye Conditions --- Please list

_____

Do you currently or have you recently experienced any of the following? (check box if yes)

☐ Blurred Vision ☐ Burning Eyes ☐ Floaters ☐ Headaches ☐ Itching Eyes

☐ Watery Eyes ☐ Flashes of Light ☐ Double Vision ☐ Red Eyes ☐ Sandy/gritty feeling

☐ Loss of Vision ☐ Eye Strain ☐ Dry Eyes ☐ Eye Pain ☐ Poor Night Vision

☐ Light Sensitivity ☐ Eye fatigue

Please check all that apply:

GENERAL	☐ Weight Change ☐ Fatigue ☐ Difficulty Walking
HEART	☐ High Cholesterol ☐ Hypertension ☐ Heart Attack ☐ Cardiac Disease
LUNGS	☐ Asthma ☐ Snoring ☐ Sleep Apnea ☐ COPD
GASTRO INTESTINAL	☐ Ulcers ☐ Reflux Disease ☐ Hepatitis
KIDNEY	☐ Stones ☐ Renal Failure ☐ Prostate ☐ UTI
MUSCULO SKELETAL	☐ Arthritis ☐ Fractures ☐ Weakness ☐ TMJ
ENDOCRINE	☐ Thyroid ☐ Diabetes
NEUROLOGICAL	☐ Migraines ☐ Head Trauma ☐ Stroke ☐ Multiple Sclerosis
IMMUNODEFICIENCY	☐ Seasonal Allergies ☐ Autoimmune ☐ Sinusitis ☐ HIV
PSYCHIATRIC	☐ Depression ☐ Anxiety ☐ Psychosis
OTHER	