EliteEyeCare
A MEMBER OF VISION SOURCE

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DEMOGRAPHICS	CONTACT INFORMATION
Last Name First Name MI	What is the best way for us to reach you: □ Cell □ Email □ Home □ Work
Address City, State, Zip	Cell Phone _____
Date of Birth:	Home Phone _____
Social Security #: Sex:	Work Phone _____
Marital Status: □ Single □ Married Spouse:	Email:
Employer: Position:	Is it okay to send reminders via: □ Text □ Email
How did you hear about our office? □ Internet □ Insurance Listing □ Friend/Relative □ Another Dr. □ Other	Emergency Contact: Emergency Phone:

What is the main reason for this visit?

Date of last eye exam: By whom: How old is current eyewear:

Current contact lens wearer: □ Yes □ No Brand: Solution:

How often do you replace your contacts? Do you sleep in your contacts? □ Yes □ No

PERSONAL HEALTH HISTORY

Family Physician:_____ Clinic:_____ Date of last physical:_____

List any current medications: □ none _____

List any medical allergies: □ none _____

Do you use: Cigarettes/Tobacco: □ Y □ N Alcohol: □ Y □ N Other substances: □ Y □ N

Have you had any major surgeries? □ Y □ N Type of surgery_____ Date_____

Do you experience, been diagnosed, or treated for… (Check box for yes)

□ Blurry vision	□ Cataracts	□ Iritis/Uveitis	□ Eye Infection/Injury	□ Headaches	□ Poor Night Vision
□ Burning/Itching eyes	□ Tearing	□ Floaters/Flashes	□ Lazy Eye	□ Double Vision	□ Diabetic Retinopathy
□ Macular Degeneration	□ Glaucoma	□ Corneal Abrasion	□ Light Sensitivity	□ Dry Eye Disease	□ Retinal Detachment

Have you been treated for the following health problems? If yes, please explain:

□ Constitutional (dev. Disability, fever, weight loss, fatigue) _____
□ Ear/Nose/Throat/Mouth (hearing loss, URT infection) _____
□ Neurological (multiple sclerosis, epilepsy) _____
□ Psychological _____
□ Cardiovascular (heart, high blood pressure, stroke) _____
□ Respiratory _____
□ Gastrointestinal (Crohn's, colitis, ulcer, digestive) _____
□ Genitourinary (kidney dysfunction, prostate/ovarian cancer) _____
□ Muscles/Joints (osteoarthritis, weakness) _____
□ Skin (eczema, rosacea, rash, dryness) _____
□ Endocrine (diabetes, hyper/hypo thyroid) _____
□ Blood (anemia/leukemia) _____

Has anyone in your family been treated for…?

□ Blindness _____
□ Glaucoma _____
□ Macular Degeneration _____
□ Diabetes _____
□ Cataracts _____
□ Lazy Eye _____
□ High Blood Pressure _____
□ Retinal Problems _____
□ Other (Please Specify) _____

PRIVACY PRACTICES ACKNOWLEDGEMENT AND INSURANCE PAYMENT AUTHORIZATION

I acknowledge that I have received a copy of the Notice of Privacy Practices of Elite Eye Care to review. I also authorize the payment of any eye care benefits or medical insurance to my Doctor of Optometry for goods or services rendered. I permit a copy of this authorization to be used in place of the original signature and authorize release of medical information necessary to pay the claim. I understand that I may have co-payments, deductibles, and overage costs, and ultimately I am responsible for all fees incurred, and that payment is expected at the time of service or at the time of ordering. If I have Medicare, I understand that my signature request payment of authorized Medicare benefits be made on my behalf to Elite Eye Care, for any goods/services furnished to me by that physician/supplier.

Name _____ Signature _____ Date _____
(Parent/Guardian if under age 18)