

Cleveland Eyecare

Welcome To Our Office

Dr. Hamrick and staff at Cleveland Eyecare welcome you to our practice. Our mission is to provide excellent professional care to all patients allowing us to safeguard and optimize your most precious sense – the gift of sight. We look forward to serving you.

Fill out the patient information sheets completely and bring them with you to your appointment.

Mr. Miss Mrs. Ms. Male Female

First Name MI Last Name Preferred Name

Street Address City State Zip

Social Security Number Date of Birth Home Phone - Include Area Code Day Phone

Email Address Guardian Person Responsible for Account

Emergency Contact Emergency Phone

How were you referred to our office?

Who were you referred by?

- Phone Book School Advertisement Patient
 Insurance Listing Drive by Other Doctor

PRIMARY INSURANCE INFORMATION

Name and Address of Primary Insurance Company City State Zip

M F

Insured's First Name MI Insured's Last Name

Insured's Identification Number Group Number Insured's Date of Birth

Patient Relationship to Insured

Patient Status

- Self Spouse Child Other Single Married Other
 Full Time Student Part Time Student Employed

SECONDARY INSURANCE INFORMATION

Name and Address of Secondary Insurance Company City State Zip

M F

Insured's First Name MI Insured's Last Name

Insured's Identification Number Group Number Insured's Date of Birth Self Spouse Child Other

Please Read:

In order to control the cost of billing, copays and deductibles are collected at the time services are rendered. All professional services and materials are charged to the patient. The undersigned will ultimately be responsible for any bill incurred regardless of insurance. Accounts 60 days old are subject to a 45% collection fee. There will be a service charge on all returned checks to cover bank charges on returned checks.

Payment from my insurance is to be paid directly to Cleveland Eyecare.

Signature _____

Date _____

Name _____

Cleveland Eyecare PATIENT HISTORY AND INFORMATION

Race

<input type="checkbox"/> American Indian Or Alaska Native	<input type="checkbox"/> Native Hawaiian Or Other Pacific Islander
<input type="checkbox"/> Asian	<input type="checkbox"/> White
<input type="checkbox"/> Black Or African American	<input type="checkbox"/> Declined To Specify
<input type="checkbox"/> Hispanic Or Latino	

Other Race _____

Ethnicity

Hispanic Or Latino Not Hispanic Or Latino Declined To

Preferred Language

English Chinese Dutch; Flemish French German Hindi

Height	ft	in	cm/m	<input checked="" type="radio"/> ft in	<input type="radio"/> cm	<input type="radio"/> m	Weight	<input type="radio"/> lbs	<input type="radio"/> kg
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>				<input type="text"/>		

PRIMARY CARE PHYSICIAN

Primary Care Physician and Clinic Name _____

Address of Primary Care Physician _____

City _____

State _____

Zip _____

Phone _____

REFERRING PHYSICIAN

Referring Physician and Clinic Name _____

Address of Referring Physician _____

City _____

State _____

Zip _____

Phone _____

HEALTH HISTORY

What is the main reason for today's exam ? _____ When was your last exam ? _____

When was your last health exam ? _____

Past Illnesses or Injuries: _____

Past Surgeries: _____

Current Medications: _____

Current Eye Drops: _____

Medicines that cause reactions or sensitivities: _____

Specific Allergies: _____

EYE HISTORY

Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Dryness	<input type="radio"/> Yes <input type="radio"/> No	Strabismus (Crossed Eyes)	<input type="radio"/> Yes <input type="radio"/> No
Cataract	<input type="radio"/> Yes <input type="radio"/> No	Excess Tearing/Watering	<input type="radio"/> Yes <input type="radio"/> No	Blurred Vision Distance	<input type="radio"/> Yes <input type="radio"/> No
Macular Degeneration	<input type="radio"/> Yes <input type="radio"/> No	Eye Pain or Soreness	<input type="radio"/> Yes <input type="radio"/> No	Blurred Vision Near	<input type="radio"/> Yes <input type="radio"/> No
Retinal Detachment	<input type="radio"/> Yes <input type="radio"/> No	Foreign Body Sensation	<input type="radio"/> Yes <input type="radio"/> No	Distorted Vision (halos)	<input type="radio"/> Yes <input type="radio"/> No
Color Blindness	<input type="radio"/> Yes <input type="radio"/> No	Infection of Eye or Lid	<input type="radio"/> Yes <input type="radio"/> No	Double Vision	<input type="radio"/> Yes <input type="radio"/> No
Headaches	<input type="radio"/> Yes <input type="radio"/> No	Itching	<input type="radio"/> Yes <input type="radio"/> No	Floaters or Spots	<input type="radio"/> Yes <input type="radio"/> No
Glare/Light Sensitivity	<input type="radio"/> Yes <input type="radio"/> No	Mucous Discharge	<input type="radio"/> Yes <input type="radio"/> No	Fluctuating Vision	<input type="radio"/> Yes <input type="radio"/> No
Tired Eyes	<input type="radio"/> Yes <input type="radio"/> No	Drooping Eyelid	<input type="radio"/> Yes <input type="radio"/> No	Loss of Vision	<input type="radio"/> Yes <input type="radio"/> No
Amblyopia (Lazy Eye)	<input type="radio"/> Yes <input type="radio"/> No	Redness	<input type="radio"/> Yes <input type="radio"/> No	Loss of Side Vision	<input type="radio"/> Yes <input type="radio"/> No
Burning	<input type="radio"/> Yes <input type="radio"/> No	Sandy or Gritty Feeling	<input type="radio"/> Yes <input type="radio"/> No		

GENERAL HEALTH CONDITION

Fever	<input type="radio"/> Yes <input type="radio"/> No	Respiratory (Asthma)	<input type="radio"/> Yes <input type="radio"/> No	Anxiety or Depression	<input type="radio"/> Yes <input type="radio"/> No
Weight Loss	<input type="radio"/> Yes <input type="radio"/> No	Gastrointestinal	<input type="radio"/> Yes <input type="radio"/> No	Thyroid, Diabetes	<input type="radio"/> Yes <input type="radio"/> No
Other Symptoms	<input type="radio"/> Yes <input type="radio"/> No	Kidney	<input type="radio"/> Yes <input type="radio"/> No	Blood/Lymph	<input type="radio"/> Yes <input type="radio"/> No
Ears,Nose,Throat	<input type="radio"/> Yes <input type="radio"/> No	Muscles,Bones, Joints	<input type="radio"/> Yes <input type="radio"/> No	Allergic	<input type="radio"/> Yes <input type="radio"/> No
Cardiovascular (high blood pressure etc.)	<input type="radio"/> Yes <input type="radio"/> No	Skin	<input type="radio"/> Yes <input type="radio"/> No	Pragrent	<input type="radio"/> Yes <input type="radio"/> No
		Neurological (Multiple Sclerosis)	<input type="radio"/> Yes <input type="radio"/> No	Nursing	<input type="radio"/> Yes <input type="radio"/> No

Name _____

Cleveland Eyecare

MEDICAL HISTORY QUESTIONNAIRE

FAMILY HISTORY

Amblyopia (Lazy Eye)	<input type="radio"/> Yes <input type="radio"/> No	Retinal Detachment	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No
Blindness	<input type="radio"/> Yes <input type="radio"/> No	Strabismus (Eye Turn)	<input type="radio"/> Yes <input type="radio"/> No	Kidney Disease	<input type="radio"/> Yes <input type="radio"/> No
Cataract(s)	<input type="radio"/> Yes <input type="radio"/> No	Arthritis	<input type="radio"/> Yes <input type="radio"/> No	Lupus	<input type="radio"/> Yes <input type="radio"/> No
Color Blindness	<input type="radio"/> Yes <input type="radio"/> No	Cancer	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Macular Degeneration	<input type="radio"/> Yes <input type="radio"/> No	Heart Disease	<input type="radio"/> Yes <input type="radio"/> No	Others	<input type="radio"/> Yes <input type="radio"/> No

SOCIAL HISTORY

Current Occupation : _____ Years _____ Employer _____

SPECTACLE LENS HISTORY

Do you use a computer? Yes No How many hours/day? _____ Distance from Computer? _____

Do you drive? Yes No Mileage to work each way? _____

Do you have glare problems? Yes No

Do you have visual difficulty when driving? Yes No

Do you have problems with night vision? Yes No

Do you currently wear glasses ? Yes No Since _____

Type of glasses FullTime PartTime Distance Close

Glasses Owned SingleVision Bifocals Trifocals Backup Safety Sports Progressive

Have you had trouble in the past with glasses? Yes No _____

Do you wear sunglasses? Yes No Are your sun glasses your current prescription ? Yes No

SPECIAL EYEWEAR NEEDS

Computer (special prescriptions, special anti-glare tints or coatings) Safety Glasses (gardening, woodworking, welding)

Occupational (mechanics, plumbers, pilots) Sports/Hobbies (racquet sports, motorcycle)

CONTACT LENS HISTORY

If not a contact lens wearer, are you interested in trying contact lenses at this time ? Yes No

Have you ever tried to wear contact lenses? Yes No Reason for stopping? _____

Do you currently wear contact lenses? Yes No Since _____

Type and brand of contact lenses _____ Today's wearing time ? _____

How many hours/day ? _____ How many days/week ? _____

Please rate the following on a scale of 1-10, with 1 being POOR to 10 being EXCELLENT

Lens Comfort Right Left Distance Vision Right Left Near Vision Right Left
What Solutions do you use? Cleaner _____ Disinfectant _____ Enzyme _____

Name

Cleveland Eyecare

SOCIAL HISTORY

Do you use nutritional supplements (vitamins etc.)? Yes No
Do you engage in regular exercise? Yes No
Do you drink alcohol ? If yes, how much/often : No Occasional 1 Per Day 2-3/day 4+/day
Do you smoke ? If yes, how much/often : No Occasional 1/2 pack/day 1 pack/day 1+ pack
Smoking Status
Method of Tobacco Intake : _____
 Smoking Chewing
Do you use Illegal Drugs : Yes No
Hobbies/ Interests : _____

Bring with you your most current glasses.

If you wear contact lenses wear them to your appointment.

Bring all insurance cards, vision and major medical.

Bring a list of medication, prescription and over the counter, including any eye drops.

Bring some form of payment for your copays and/or deductibles.

We accept cash, checks, mastercard/visa/discover/debit, and care credit.

If you have any question about your insurance please contact your insurance company prior to the day of appointment. We are available to assist you with this at 704-482-1234.

We look forward to seeing you at your scheduled appointment.

**Cleveland Eyecare
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