EYE CENTER of Ephraim

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New Patient Information. (*please print*)

Name_____
Mailing Address_____
City_____Zip Code_____
Home Phone_____Cell Phone _____
Date of Birth_____ Age_____
Email_____
Preferred Language: ☐ English ☐ Spanish
Communication Preference: ☐ Email ☐ Postal ☐ Telephone

Occupation _____☐full-time ☐part-time
Employer_____
Employer Phone_____
Social Security Number_____
☐ Male ☐Female
☐ Single ☐Married ☐Divorced ☐Widowed
Race _____
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Spouse's Name _____Date of Birth _____
Spouse's Social Security Number _____

If you are a student or under 18 years of age, please complete this section.

Name of Father_____
Father's Date of Birth_____
Address_____
Father's Social Security Number_____
Father's Occupation_____ ☐full-time ☐part-time
Father's Employer_____
Employer's Address_____
Work Phone_____

Name of Mother_____
Mother's Date of Birth_____
Address_____
Mother's Social Security Number_____
Mother's Occupation_____ ☐full-time ☐part-time
Mother's Employer_____
Employer's Address_____
Work Phone_____

Insurance Information

Primary Insurance_____
Address_____
Policyholder Name_____
Date of Birth_____ID#_____Group#_____

Secondary Insurance_____
Address_____
Policyholder Name_____
Date of Birth_____ID#_____Group#_____

Self Pay Information

Are you personally responsible for payment? ☐Yes ☐No Who is? _____Relationship_____

Emergency Information *(Who to notify - nearest relative or friend)*

Name_____ Relationship_____
Home Phone_____ Work Phone_____ Cell Phone_____

Those we may talk to about your eye conditions

Name(s)_____

(Family, friends, etc. or write "none" if you don't want information discussed with anyone.)

CONSENT FOR TREATMENT/RELEASE

I hereby authorize the Eye Center of Ephraim to administer such medication and to perform such optical procedures as may be necessary for proper optometric care. I authorize the Eye Center of Ephraim to release my medical information to other medical professionals if a referral is needed for the continuation of my care. I authorize the release my prescription to optical labs and other suppliers, given that my prescription is current and not out dated.

FINANCIAL ASSIGNMENT AND AGREEMENT

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.** In order to control your cost of billings, we request that your charges for office visits be paid at the conclusion of each visit unless you are covered by Medicare.

I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to be released to the Health Care Financing Administration, its agents, or any insurance carrier(s) I may have, any information needed to determine these benefits or the benefits payable for related services.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment. **I also understand that I will pay all balances due to the Eye Center of Ephraim in a timely manor. I agree to pay 1.5% interest on all past amounts of 30 days of more, not to exceed 18% annually. I agree to pay for all fees resulting from any action taken by, but not limited to, a collection agency and/or attorneys, court fees, filing, and service fees, not to exceed 50% of the principal balance including interest.**

_____ _____

Signature of Patient (or parent if patient is a minor) *Date* *10/06/11*

Medical History Questionnaire

Name: _____ Today's Date: ____ / ____ / ____

Address: _____ Phone: _____

City: _____ Zip: _____ Work Phone: ____ _____

Guardian (If Applicable): _____ Occupation: _____

Birth Date: ____ / ____ / ____ Social Security #: ____ / ____ / ____ Last Eye Exam: ____ / ____ / ____

Name of Medical Doctor: _____ Dr.'s Phone: _____

Last Medical Exam: ____ / ____ / ____

Medical History

Do you have any allergies to medications? ❒ no ❒ yes If yes, explain: _____

_____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

_____

_____

_____

List all major injuries, surgeries and/or hospitalizations you have had: _____

_____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: _____

Are you pregnant and/or nursing? ❒ no ❒ yes

Do you wear glasses? ❒ no ❒ yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? ❒ no ❒ yes If yes, how old is your present pair of lenses? _____

Type of contact lenses: ❒ Rigid ❒ Soft ❒ Extended Wear ❒ Other Are they comfortable? ❒ yes ❒ no

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	❒	❒	❒	_____
Cataract	❒	❒	❒	_____
Crossed Eyes	❒	❒	❒	_____
Glaucoma	❒	❒	❒	_____
Macular Degeneration	❒	❒	❒	_____
Retinal Detachment/Disease	❒	❒	❒	_____
Arthritis	❒	❒	❒	_____
Cancer	❒	❒	❒	_____
Diabetes	❒	❒	❒	_____
Heart Disease	❒	❒	❒	_____
High Blood Pressure	❒	❒	❒	_____
Kidney Disease	❒	❒	❒	_____
Lupus	❒	❒	❒	_____
Thyroid Disease	❒	❒	❒	_____
Other _____	❒	❒	❒	_____

✱ Please turn this form over and complete side two ✱

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

❒ Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive? ❒ no ❒ yes If yes, do you have visual difficulty when driving? ❒ no ❒ yes If yes, please describe:

_____

Do you use tobacco products? ❒ no ❒ yes If yes, type/amount/how long: _____

Do you drink alcohol? ❒ no ❒ yes If yes, type/amount/how long: _____ _____

Do you use illegal drugs? ❒ no ❒ yes If yes, type/amount/how long: _____ _____

Have you ever been exposed to or infected with: ❒ Gonorrhea ❒ Hepatitis ❒ HIV ❒ Syphilis

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss/Gain	❒	❒	❒
INTEGUMENTARY (Skin)	❒	❒	❒
NEUROLOGICAL			
Headaches	❒	❒	❒
Migraines	❒	❒	❒
Seizures	❒	❒	❒
EYES			
Loss of Vision	❒	❒	❒
Blurred Vision	❒	❒	❒
Distorted Vision/Halos	❒	❒	❒
Loss of Side Vision	❒	❒	❒
Double Vision	❒	❒	❒
Dryness	❒	❒	❒
Mucous Discharge	❒	❒	❒
Redness	❒	❒	❒
Sandy or Gritty Feeling	❒	❒	❒
Itching	❒	❒	❒
Burning	❒	❒	❒
Foreign Body Sensation	❒	❒	❒
Excess Tearing/Watering	❒	❒	❒
Glare/Light Sensitivity	❒	❒	❒
Eye Pain or Soreness	❒	❒	❒
Chronic Infection of Eye or Lid	❒	❒	❒
Sties or Chalazion	❒	❒	❒
Flashes/Floaters in Vision	❒	❒	❒
Tired Eyes	❒	❒	❒
ENDOCRINE			
Thyroid/Other Glands	❒	❒	❒

	NO	YES	?
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	❒	❒	❒
Sinus Congestion	❒	❒	❒
Runny Nose	❒	❒	❒
Post-Nasal Drip	❒	❒	❒
Chronic Cough	❒	❒	❒
Dry Throat/Mouth	❒	❒	❒
RESPIRATORY			
Asthma	❒	❒	❒
Chronic Bronchitis	❒	❒	❒
Emphysema	❒	❒	❒
VASCULAR / CARDIOVASCULAR			
Diabetes	❒	❒	❒
Heart Pain	❒	❒	❒
High Blood Pressure	❒	❒	❒
Vascular Disease	❒	❒	❒
GASTROINTESTINAL			
Diarrhea	❒	❒	❒
Constipation	❒	❒	❒
GENITOURINARY			
Genitals/Kidney/Bladder	❒	❒	❒
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	❒	❒	❒
Muscle Pain	❒	❒	❒
Joint Pain	❒	❒	❒
LYMPHATIC / HEMATOLOGIC			
Anemia	❒	❒	❒
Bleeding Problems	❒	❒	❒
ALLERGIC / IMMUNOLOGIC	❒	❒	❒
PSYCHIATRIC	❒	❒	❒

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

_____

_____

_____

_____

_____

_____ _____

Doctor's Signature Date