WELCOME TO OUR OFFICE

Today's Date _____

Patient Information

Last _____
First _____MI _____
Street _____
City _____ State _____
Zip Code _____
Home Phone _____
Work Phone _____
Cell Phone _____
Employer (or School) _____
Occupation (or Grade) _____
Spouse (or Parent's Name) _____
Date of Birth _____Age _____
Sex M F
Email Address _____

VERY IMPORTANT! NEW PATIENTS ONLY:
Who may we thank for referring you to our office?

_____

If not referred, how did you choose our office?
❑ Another Dr.
❑ Insurance List
❑ Saw Sign/Building
❑ Newspaper/Radio/TV
❑ Yellow Pages: Which directory? _____
❑ Web Page: Which Web Site? _____
❑ Other _____

Communication Options

We currently send appointment reminders and appointment requests using e-mails and/or text messages. We do not release this information to any third parties. Please choose one of the following. You may change your preferences at anytime.

❑ E-mail
❑ Text Messages
❑ Both
❑ Phone call only

AMERICAN EYECARE CENTER

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment and understand I am responsible for any fee not paid by my insurance.

X_____

Insurance Information

Routine Vision Insurance_____
Subscriber Name_____
Subscriber id # _____
SS#_____
Subscriber Birth Date_____

Medical Insurance_____
Subscriber Name_____
Subscriber id # _____
SS#_____
Subscriber Birth Date_____

Do you participate in a Flex Spending Account or Health Savings Account?
❑ Yes ❑ No

Notices

I understand the HIPPA Notice of Privacy Practices
Initial _____

I understand the Missed Appointment and Cancellation Policy
Initial _____

The information in this confidential case history form is critical to the evaluation of your vision and health.

Family Eye History (Check all that apply)

Is there a family medical history of any of the following:

Blindness ❑
Cataracts ❑
Corneal Problems ❑
Diabetic Eye Disease ❑
Glaucoma ❑
Lazy Eye ❑
Macular Degeneration ❑
Retinal Problems ❑

Patient Medical History

Name of Family Physician_____
Town_____
How long has it been since your last physical?
_____

Please list all medications you are currently taking including eye drops, vitamins, birth control, and over the counter. _____
_____
_____
_____

Please list any allergies to medications. ❑None known
_____

How long has it been since your last eye exam?
_____

Please list any previous eye injuries or surgeries.
_____
_____
_____
_____
_____
_____
_____

Patient Medical History

Have you ever experienced, been diagnosed or treated for any of the following?

❑ Blurry Vision
❑ Double Vision
❑ Crossed /Lazy Eye
❑ Floaters
❑ Flashes of light
❑ Dry Eyes
❑ Burning Eyes
❑ Itchy Eyes
❑ Tearing
❑ Cataracts
❑ Glaucoma
❑ Macular Degeneration
❑ Retinal Detachment
❑ Corneal Abrasion
❑ Sunlight Sensitivity
❑ Trouble seeing at night
❑ Eye Surgery
❑ Eye Injury

❑ Other eye disorders_____

Have you ever been diagnosed or treated for the following health problems?	**Yes**	**No**
Allergies	❑	❑
Arthritis	❑	❑
Blood/Lymph	❑	❑
Bronchitis	❑	❑
Cancer	❑	❑
Cholesterol	❑	❑
Diabetes	❑	❑
Digestive	❑	❑
Ears/Nose/Throat	❑	❑
Endocrinc	❑	❑
Eczema/Rashes	❑	❑
Fatigue	❑	❑
Fevers	❑	❑
Genitourinary	❑	❑
High Blood Pressure	❑	❑
Integumentary (Skin)	❑	❑
Kidney	❑	❑
Muscle/Bone	❑	❑
Neurological	❑	❑
Psychological	❑	❑
Respiratory	❑	❑
Sinus	❑	❑
Throat Infections	❑	❑
Thyroid	❑	❑
Unusual weight losses/gains	❑	❑