PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All information will be confidential.

Date:________________

Patient Name:____ Home Phone____________
First Middle Last

Address:____ State:__________ Zip:__________

SSN:____________________ ☐ Male ☐ Female Birthdate:______________

Check the appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's or parents employer:________________________________ Work Phone:____________

Business Address:________________________________ City/State:____________

If patient is a student, name of school/college:____________________ City/State:__________ Zip:________

Person to contact in case of emergency:________________________ Phone:____________

Responsible Party

Name of person responsible for this account:____________________ Relationship to the patient____________

Address:____ Home Phone:____________

Birthdate:______________ Financial institution:________________________________

Employer:____ Work Phone:____________

Is this person currently a patient of our office? ☐ Yes ☐ No (Full payment is due and expected the day services are rendered for discounts)

Insurance Information

Vision Insurance ☐ None

☐ EyeMed ☐ VSP ☐ Farm Bureau
☐ Vision One ☐ Davis ☐ Coast to Coast

Insurance Co.:______________ Group #:__________

Address:________________________________

Employer:______________ Work Phone:__________

Name of insured:______________ Relationship:__________

DOB:________ SSN:__________ Date employed:__________

Deductible? Yes No Amount:__________

Medical Insurance ☐ None

Medicare #:____________________

BC/BS (Wellmark) #:____________________

Iowa Title 19 #:____________________

Insurance Co.:______________ Group #:__________

Address:________________________________

Employer:______________ Work Phone:__________

Name of insured:______________ Relationship:__________

DOB:________ SSN:__________ Date employed:__________

Deductible? Yes No Amount:__________

HIPPA Authorization & Release of Medical Information

I authorize release of any information concerning myself, or my child's health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me, be made directly to the doctor(s) today and in the future.

I acknowledge that I was offered/received a copy of American Eyecare's Notice of Privacy Practices. (If patient is under guardianship, legal guardian should sign as well).

______________________________ ______________
Signature of patient or parent/guardian if a minor. Date.

Family members at home Age

Family members at home	Age

If we can do anything special for you, Please ask!

Medical Information

Personal/Social History

Occupation:______________________ Visual demands? ☐ Distance ☐ Reading ☐ Computer ☐ Welding ☐ Power tools ☐ High speed objects?

Are you pregnant or nursing? ☐ No ☐ Yes Do you smoke? ☐ No ☐ Yes________pkg/day Alcohol consumption________/day ☐ social only

Have you ever been infected with a communicable disease ☐ No ☐ Yes Explain:______________________

Do your eyes: ☐ Blur ☐ Burn ☐ Itch ☐ Dry ☐ Sandy/Gritty ☐ Water ☐ Distorted/Halos ☐ Loss of vision ☐ Double vision ☐ Discharge ☐ Foreign body sensations ☐ Redness Other, explain:______________________

Review of Organ Systems: (Please circle all systems that you have been diagnosed with and list the specific condition in **Present Illness** and your medications)

No known medical conditions	Thyroid/Hormone/Glands	Neurological	Lymphatic/Hematological
Ears/Nose/Mouth/Throat	Collagen-vascular disorders	Respiratory	Stomach/Intestine/Colon
Bone/Joint/Muscle	Genital/Bladder/Kidney	Psychiatric	Skin diseases/disorders

Your Family Medical Doctor?______________________ **Pharmacy:**______________________

Medication Allergies:______________________

Current Medications:	Dosages	**Present Illness:** (chronic & acute)	Date diagnosed
☐ None		☐ None	

Family History (Please list your blood relatives that have been diagnosed with the following:)

Blindness:______	Diabetes:______
Cataract:______	Heart Disease:______
Crossed eyes:______	High blood pressure:______
Glaucoma:______	Kidney disease:______
Macular degeneration:______	Lupus:______
Retinal detachment:______	Thyroid disease:______
Cancer:______	Other:______

Stop Here…. Thank you for completing this form. Please return it to the receptionist.

Date of onset	D/C date	Doctors Problem list	ICD-9	Treatment/Plan/Monitor
		1.		
		2.		
		3.		
		4.		
		5.		
		6.		
		7.		
		8.		
		9.		
		10.		
		11.		
		12.		

Tech											
Date reviewed											
Doctor											