

Today's Date ____/____/____



Patient Information

Title: Dr. Mr. Mrs. Ms.

Last Name: _____ First Name: _____ Middle Initial: _____

Preferred Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Birth Date: ____/____/____ Age: _____

Social Security #: _____ - _____ - _____

Sex: M F Marital Status: S M D W

May we leave a message on your phones?

Home: _____ Yes No

Cell: _____ Yes No

Other: _____ Yes No

Emergency Contact: _____

Phone: _____

May we contact you via email? Yes No

Email: _____

If the patient is a minor:

Guardian: _____

Relationship to patient: _____

Phone: _____

Insurance Information

Primary Insurance: _____

ID #: _____

Insured's Name: _____

Birth Date: ____/____/____ SSN: ____ - ____ - ____

Relationship to insured: self spouse dependent

Employer's Name: _____

Secondary Insurance: _____

ID #: _____

Insured's name: _____

Birth Date: ____/____/____ SSN: ____ - ____ - ____

Relationship to insured: self spouse dependent

Family History Information

Have any of your blood relatives, living or deceased, had any of the following conditions?

Glaucoma Yes No Retinal Disease/Detach Yes No Diabetes Yes No
Cataract Yes No Blindness Yes No High Blood Pressure Yes No
Crossed Eyes Yes No Cancer Yes No Heart Disease Yes No
Macular Degeneration Yes No Kidney Disease Yes No

Referral

How did you hear about us? (circle all that apply)

Insurance list Sign/Marketing Phonebook Website Friend/Family _____

Personal Medical/Ocular History Information

Medical History

Have you ever been diagnosed with any of the following? (Please answer all yes or no)

Diabetes	Yes	No	Kidney/Liver Disease	Yes	No
High Blood Pressure	Yes	No	Hypo/Hyperthyroidism	Yes	No
Heart Disease	Yes	No	Cancer	Yes	No
High Cholesterol	Yes	No	Stroke	Yes	No

Do you take any medications on a regular basis? Yes No Please list below:

Do you have allergies? (medications, other) Yes No Please list below:

Do you smoke? Yes No Do you drink alcohol? Yes No Are you pregnant/nursing? Yes No

Ocular History

Who performed your last eye exam? _____ When? _____

Have you ever been diagnosed with any of the following? (Please answer all yes or no)

Glaucoma	Yes	No	Macular Degeneration	Yes	No
Cataracts	Yes	No	Retinal Disease/Detach	Yes	No
Corneal Disease	Yes	No	Crossed Eyes	Yes	No

Have you ever had surgery on your eyes? Please list: _____

Please list all eye medicines: _____

What is the reason for your visit today? (Please check all that apply)

Distance vision blur	Yes	No	Glaucoma	Yes	No
Near vision blur	Yes	No	Cataracts	Yes	No
New contact lenses	Yes	No	Red eyes	Yes	No
New glasses	Yes	No	Painful eyes	Yes	No

How old are your current glasses? _____

If you wear contacts, what brand? _____ Are you satisfied with them? Yes No

Please list the name of any specific individuals to whom we may release personal medical/vision information:

Acknowledgement of Receipt of Privacy Policies

I have been presented with the Notice of Privacy Practices of Anderson Eye Care, PLLC and have been offered a copy of the policy to keep for my records.

Signature of patient/guardian _____ Date _____

Insurance Authorization

I request payment for authorized insurance benefits for any services furnished me, be made on my behalf to Anderson Eye Care, PLLC.

I authorize any holder of medical information about me to be released to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand that Anderson Eye Care, PLLC makes every effort to verify the benefits provided by my insurance carrier, but the benefits expressed by Anderson Eye Care, PLLC is no guarantee of payment by said insurance carrier. I understand that I am responsible, in full, for charges not paid by the insurance plan.

Signature of patient/guardian _____ Date _____

Contact Lens Patient Agreement

I acknowledge that I have been properly instructed in the care of my contact lenses and understand that my failure to follow all the instructions may result in unsatisfactory service from my lenses and could result in injury to my eyes. I understand the fragility of contact lenses and that there is no warranty against damage of these lenses. Also, I have been instructed and have practiced insertion and removal of my lenses. I understand that if I experience sudden or prolonged red eyes, or prolonged irritation, I should call this office immediately.

I understand that the contact lens prescription will not be released until all progress visits are completed. The prescription is valid for replacement lenses for a period of one year. After one year, an annual contact lens examination will be required to update this prescription for replacement lenses.

I understand that each contact lens fitting fee includes all my contact lens related progress visits for a period of 45 days.

Signature of patient/guardian _____ Date _____