

CONFIDENTIAL CASE HISTORY

Date: _____

Name: (L) _____ (F) _____ (MI) _____ Age: _____ Sex: _____

Address: _____ Apt. _____ City/State: _____ Zip: _____
Lot _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ SSN: _____

Date of Last Exam: _____ Previous Eye Doctor: _____

Medical Insurance: _____ Vision Insurance: _____

Secondary Insurance (if applicable): _____

How did you hear about us? (check one) Phone Book Passing by the Office Radio Newspaper
 T.V. Friend or Family (Who) _____

Have you been examined here before? If so, when? _____

Do you have any of the following?

High Blood Pressure.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Glaucoma.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Diabetes.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Cataracts.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Cancer.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Double Vision.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Thyroid Problems.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Frequent Headaches.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Arthritis.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Seeing Spots or Flashes.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Eye Turn or "Lazy Eye".....	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Any Eye Disease?.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Other medical conditions? _____

Females ----- Are you pregnant? YES NO If so, how many weeks? _____

Do any blood relatives have any of the following? (Specify who on the line)

Diabetes? _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Cataracts? _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Glaucoma? _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Any eye disease? _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Please list all current medications you are taking (including any over the counter and birth control): _____

Please list all allergies that you have (INCLUDING ALLERGIES TO MEDICATIONS): _____

Have you ever had eye surgery? YES NO. If yes, please describe: _____

Do you currently wear glasses? YES NO
Are you currently wearing contacts? YES NO
Do you want contacts today? YES NO

Payment is due at the time services are rendered. Primary Eyecare accepts assignment with insurance companies with which we have contractual agreements. Patients are responsible for co-pays and deductibles. Medical insurance usually does not cover routine eye exams unless related to a medical diagnosis such as diabetes, headaches, allergies, etc. I understand that payment is expected at the time of service and that I am responsible for all charges. In the event an account becomes delinquent, I agree to pay all charges including potentially necessary collection and attorney fees.

Authorization for Release of Medical Information: Primary Eyecare and attending optometric physicians are authorized to furnish any medical information requested by insurance companies or public agency which may be assisting in the payment of services. I authorize my insurance company to make payment to Primary Eyecare.

I acknowledge that a copy of Primary Eyecare's Notice of Privacy Practice has been provided and further authorize contacting me or leaving a message at numbers that I have provided.

X _____
Patient or Responsible Party Signature Date

Additional Information

If you are not the insured (if the insurance is through a spouse or parent), please provide the following information:

Insured's Name: _____

Relation to Insured: _____

Insured's SSN: _____ Insured's DOB: _____

Address if different from patient: _____

If the patient is a minor (child), please provide responsible party information.

Name: _____

SSN: _____

D.O.B.: _____

Address, if different: _____