Welcome to Primary Eyecare Associates

We want to welcome you to our practice and appreciate that you have chosen us as your family eye care provider. We believe that there is still a personal touch in medical eye care and strive to offer that family relationship to our patients. This diagnostic form will help us in evaluating both your vision and your total eye and body health. Please take a few moments to complete it. Again, welcome to Primary Eyecare Associates.
PLEASE USE ONLY BLACK INK Date: _____

Name: Last: _____ First:_____ M.I. _____ Title:_____

Address: _____ City: _____ State:_____ Zip: _____

Date of Birth: _____ Age: _____ SS#: _____Marital Status: _____

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

Employer: _____ Occupation: _____

Hobbies/Interests?_____ Email address:_____

Medical Insurance: _____ Vision Insurance: _____

Secondary Insurance (if applicable): _____

How were you referred to our office?

☐ Friend or family member: _____	☐ Insurance Company	☐ Yellow Pages
☐ Family Doctor: _____	☐ Received mailing	☐ Newspaper
☐ Ophthalmologist: _____	☐ Internet	☐ Other _____

If this form was filled out by someone other then the patient, please list name and relation: _____

OCULAR HISTORY

Have you ever been diagnosed with any of the following conditions?

Cataract	☐ Yes ☐ No	Age related macular degeneration	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Dry Eye	☐ Yes ☐ No	Diabetic Retinopathy	☐ Yes ☐ No
Eye infection	☐ Yes ☐ No	Eye Inflammation	☐ Yes ☐ No
Eye Allergy	☐ Yes ☐ No	Floaters and/or Flashes	☐ Yes ☐ No
Iritis / Uveitis	☐ Yes ☐ No	Retina defects or degeneration	☐ Yes ☐ No
Lazy Eye	☐ Yes ☐ No	Eye accident / trauma	☐ Yes ☐ No

Any other conditions? _____

Do you have any of the following concerns?

Redness	☐ Yes ☐ No	Burning	☐ Yes ☐ No	Itching	☐ Yes ☐ No
Tearing	☐ Yes ☐ No	Discharge	☐ Yes ☐ No	Glare	☐ Yes ☐ No

MEDICAL HISTORY

Date of last eye exam: _____ Where did you get your last eye exam: _____

Date of last physical exam: _____ Name of Primary Care Physician: _____

Review of Systems: Many diseases of the body have serious eye health consequences. Please answer the following questions. While they may seem unrelated to an eye problem, it is crucial to your care that we ask them.

Do you currently have any of the following problems?	**Yes**	**No**	**If YES, please explain**:
Chronic fever, unexpected weight loss/gain, fatigue …….……..	☐	☐	_____
Ear/nose/throat problems (eg hearing loss, sinus problems, sore throat) ……..…	☐	☐	_____
Neurological problems (eg numbness, weakness, headaches, "blackouts") …….	☐	☐	_____
Psychiatric problems (eg depression, anxiety) ……	☐	☐	_____
Cardiovascular problems (eg high blood pressure, heart disease, high cholesterol)…	☐	☐	_____
Respiratory problems (eg shortness of breath, wheezing, coughing, asthma) …….	☐	☐	_____
Gastrointestinal problems (eg heartburn, reflux, abdominal pain, diarrhea, vomiting)	☐	☐	_____
Genitourinary problems (eg painful urination, blood in urine, sex organ problems) ….	☐	☐	_____
Musculoskeletal problems (eg arthritis, joint pain, muscle pain) …….	☐	☐	_____
Skin problems (eg rashes, excessive dryness, growths or lumps) ……..	☐	☐	_____

PLEASE COMPLETE OTHER SIDE

Endocrine problems (eg diabetes, high or low acting thyroid, heat intolerant) …… ☐ ☐ _____
Blood/Lymph problems (eg brusing, weakness, unusual paleness, swollen glands) ... ☐ ☐ _____
Immune problems (eg frequent infections, allergic reactions, lupus) ……... ☐ ☐ _____

Females: Are you pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No
Do you have problems with excessive snoring or diagnosed sleep apnea? ☐Yes ☐No

Have you ever been treated for any medical conditions? (eg diabetes, high blood pressure, high cholesterol, arthritis, etc) ☐Yes ☐No
If YES, please explain: _____

Have you ever had any surgery or been hospitalized? ☐Yes ☐No
If YES, please explain: _____

Do you take any medications, including over the counter medicines? ☐Yes ☐No
If YES, please list: _____
_____
_____
_____

Do you have any food, drug or environmental allergies? ☐Yes ☐No
If YES, please explain: _____

Family Medical History: Do any MEDICAL diseases run in your family (*BLOOD* relatives)? Please list relationship next to condition.

Diabetes	☐Yes ☐No	Thyroid Problems	☐Yes ☐No
High Blood Pressure	☐Yes ☐No	Cancer	☐Yes ☐No

Family Ocular History: Do any EYE diseases run in your family (*BLOOD* relatives)? Please list relationship next to condition.

Glaucoma	☐Yes ☐No	Cataract	☐Yes ☐No
Macular Degeneration	☐Yes ☐No	Blindness	☐Yes ☐No

Social History:

Do you drink alcohol? ☐ No ☐ Occasionally ☐ 1 / day ☐ 2-3 / day ☐ 4+ / day
Do you smoke or use tobacco products? ☐ No ☐ Occasionally ☐ ___ pack / day ☐ >1 pack / day

Authorization to Release Information: I/We hereby authorize PRIMARY EYECARE ASSOCIATES to release any medical or incidental information that may be necessary for medical benefit or in processing applications for financial benefit. This includes but is not limited to my insurance company, rehabilitation services, Social Security Administration and worker's compensation. 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.
Office Policy on Payment: Payment is due at the time services are rendered. PRIMARY EYECARE ASSOCIATES accepts assignment with insurance companies with which we have contractual agreements. As a courtesy, my insurance will be billed for me. Patients are responsible for any co-payments, deductibles and co-insurance. Medical insurance usually does not cover a routine eye exam 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 or balances not paid for by my insurance company. I authorize insurance benefits to be paid directly to PRIMARY EYECARE ASSOCIATES. In the event an account becomes delinquent, I agree to pay all charges including potentially necessary collection and attorney fees.
Consent for Treatment: I/We hereby authorize PRIMARY EYECARE ASSOCIATES to administer diagnostic and medical procedures and treatments as may be necessary for proper health care.
Notice of Privacy Practice: I/We acknowledge that a copy of PRIMARY EYECARE's Notice of Privacy Practice has been provided and further authorize contacting me or leaving me a message at the numbers or email address provided.

_____
Patient or Responsible Party Signature **Date**

If you are not the insured member (if the insurance is through a spouse or parent), please provide the following:
Insured's Name: _____ Insured's DOB: _____

Relation to Insured: _____ Insured's SSN: _____

Address if different from patient: _____

I have reviewed this information with the patient. _____ O.D. Date: _____