



PATIENT INFORMATION

(18 Years or Older)

Patient's Name: _____ Male _____ Female _____
(Last) (First and Preferred)

Age: _____ Date of Birth: ___/___/___ Marital Status: S ___ M ___ W ___ D ___ SEP ___

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Social Security #: _____

Occupation: _____ Employer: _____

Address: _____ Phone #: _____

*Cell Phone #: _____ *Email Address: _____

*Whom can we thank for recommending us?

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Name of Spouse or Guardian: _____ Date of Birth: _____

Relationship to Patient: _____ Social Security #: _____

Home Address and Phone (If Different): _____

Occupation: _____ Employer: _____

Address: _____ Phone #: _____

Emergency Contact Name: _____ Phone #: _____

Relationship to Patient: _____ Address: _____

Primary Care Physician: _____ City: _____

Do You Have a Vision Plan: ___ No ___ Yes Name of Plan: _____

Primary Insurance Company: _____

Insurance Co. Address: _____ City/State/Zip: _____

Individual ID #: _____ Group #: _____

Policy Holder's Name: _____ Date of Birth: _____

Secondary Insurance Company: _____

Insurance Co. Address: _____ City/State/Zip: _____

Individual ID #: _____ Group #: _____

Policy Holder's Name: _____ Date of Birth: _____

Third Insurance Company: _____

Insurance Co. Address: _____ City/State/Zip: _____

Individual ID #: _____ Group #: _____

Policy Holder's Name: _____ Date of Birth: _____

Do you have a living will, advanced directive, or durable power of attorney? Yes ___ No ___ If you do, in order to honor your wishes, we need a copy in your medical record. It is your responsibility to provide that to us.

PATIENT QUESTIONNAIRE
MEDICAL INFORMATION

NAME: _____

DATE: _____

Please answer the following questions because problems elsewhere in the body may affect your eyes and vision.

PAST HISTORY

Do you have a history of any of the following? Please circle the appropriate answer.
If "yes," please provide information.

Cataract	YES	NO	_____
Glaucoma	YES	NO	_____
Macular Degeneration	YES	NO	_____
Arthritis	YES	NO	_____
Cancer	YES	NO	_____
Connective tissue disease	YES	NO	_____
Diabetes	YES	NO	_____
Heart disease (heart attack, heart surgery, etc.)	YES	NO	_____
Hepatitis	YES	NO	_____
High blood pressure	YES	NO	_____
Kidney disease	YES	NO	_____
Lung disease (asthma, emphysema, etc.)	YES	NO	_____
Stroke	YES	NO	_____
Thyroid disease	YES	NO	_____
Tuberculosis	YES	NO	_____
Other.....			_____

Please list any operations, hospitalizations, and major injuries, including approximate dates: _____

Name: _____

REVIEW OF SYSTEMS

Do you currently have any problems in the following areas?

Please circle the appropriate response.

Do you wear contact lenses? YES NO

EYES

Loss of vision	YES	NO	Itching	YES	NO
Blurred vision	YES	NO	Burning	YES	NO
Distorted vision	YES	NO	Excess tearing	YES	NO
Mucous discharge	YES	NO	Light sensitivity	YES	NO
Redness	YES	NO	Eye pain	YES	NO
			Floater and/or Flashes of light	YES	NO

CONSTITUTIONAL SYMPTOMS

Fever	YES	NO	Fatigue	YES	NO
Weight Loss	YES	NO			

EAR, NOSE, MOUTH, THROAT

Difficulty hearing	YES	NO
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SKIN

Rash	YES	NO
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CARDIOVASCULAR

Angina or chest pain	YES	NO	Rapid or irregular heartbeat	YES	NO
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PSYCHIATRIC

Depression	YES	NO	Anxiety	YES	NO
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GASTROINTESTINAL

Stomach ulcer	YES	NO
Diarrhea	YES	NO

ENDOCRINE

Excessive Thirst	YES	NO
Heat Intolerance	YES	NO
Frequency of Urination	YES	NO

GENITOURINARY

Venereal disease	YES	NO
Are you pregnant?	YES	NO

If yes, due date _____

NEUROLOGICAL

Seizures	YES	NO	Dizziness	YES	NO
Migraine	YES	NO	Difficulty swallowing	YES	NO
Headaches	YES	NO	Speech problems	YES	NO
Weakness of arms/legs	YES	NO	Numbness	YES	NO

DRUG USE YES NO

AIDS/HIV YES NO

RESPIRATORY

Chronic cough	YES	NO
Shortness of breath	YES	NO

HEMATOLOGICAL/LYMPHATIC

Anemia	YES	NO
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MUSCULOSKELETAL

Muscle pain	YES	NO
Joint pain	YES	NO

Do you have any medical problems or symptoms we have not asked you about?

YES _____ NO _____ *If "yes," please provide information.*

Do you have any blood relatives with any of the following conditions?
Please circle YES or NO. If "yes," list the relationship to you.

<u>Disease</u>			<u>Relationship to Patient</u>
Cataract	YES	NO	_____
Glaucoma	YES	NO	_____
Macular degeneration	YES	NO	_____
Retinal detachment	YES	NO	_____
Retinitis Pigmentosa	YES	NO	_____
Blindness	YES	NO	_____
Cancer	YES	NO	_____
Diabetes	YES	NO	_____
Heart disease	YES	NO	_____
High blood pressure	YES	NO	_____
Kidney disease	YES	NO	_____
Stroke	YES	NO	_____
Other.....			_____

Information Reviewed By:

Initials:

Date:

Initials:

Date:

All information on this form is confidential.

**SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS,
FINANCIAL AGREEMENT**

Patient Name: _____

Chart Number: _____ Date of Birth: _____

I accept full financial responsibility for any charges incurred today if:

1. The services rendered or supplies used/purchased are not covered under my insurance plan;
2. My insurance plan requires that I pay a deductible, co-payment, or there is a co-insurance;
3. There are charges that have resulted because I have failed to provide current and valid insurance policy information; or
4. My insurance plan requires that I obtain a referral prior to my visit and I do not have one in place.

I agree:

1. Payment be made to The Eye Care Group, PC (TECG) by my insurance carrier for services rendered or product received;
2. I understand that TECG may use and disclose medical information about me for services and procedures so they may be billed and collected from an insurance agency or any other third party;
3. To pay for my copay and other charges that are not covered by my insurance carrier today or make financial arrangements satisfactory to TECG for payment;
4. If I am not able to pay TECG for balances within 30 days, to pay a 1% interest charge, compounded, per month for my balance.
5. To pay for any returned check fees incurred by TECG.
6. If I am the parent/guardian bringing in a child for treatment, that I am responsible for all fees incurred by the child.
7. If an account is sent to collection or attorney for collection, to pay collection expenses and attorney's fees.

Date: _____ Signature: _____