The Eye Care Group
Excellence and Compassion in Eye Care

PATIENT INFORMATION TO BE COMPLETED IN FULL

Patient's Name: _____ _____ Male: _____ Female: _____
(Last) (First and Preferred)
Age: _____ Date of Birth: _____/_____/_____ Marital Status: S_____ M_____ W_____ D_____ Sep_____

Please Circle: *This information is requested due to Healthcare Reform laws dictated by Congress.*
Race: American Indian Asian Black Multi-racial Native Hawaiian White
Ethnicity: Hispanic/Latino Non-Hispanic/non-Latino
Preferred Language: English Spanish Other: _____

Home Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone #: _____ Social Security #: _____
Occupation: _____ Employer: _____
Employer Address: _____ Employer 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 No.: _____
Home Address and Phone (If Different): _____
_____
Occupation: _____ Employer: _____
Employer Address: _____ Employer Phone #: _____

Emergency Contact Name: _____ Phone #: _____
Relationship to Patient: _____ Address: _____

Primary Care Physician: _____ City: _____

Primary Insurance Company: _____
Insurance Co. Address: _____ City/State/Zip: _____
Individual ID #: _____ Group No.: _____
Policyholder's Name: _____ Date of Birth: _____

Secondary Insurance Company: _____
Insurance Co. Address: _____ City/State/Zip: _____
Individual ID #: _____ Group No.: _____
Policyholder's Name: _____ Date of Birth: _____

Third Insurance Company: _____
Insurance Co. Address: _____ City/State/Zip: _____
Individual ID #: _____ Group No.: _____
Policyholder'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.

To be used by The Eye Care Group (TECG) only.

The Eye Care Group

Medical Record #_____
(office use only)

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: _____

_____

_____

_____

_____

_____

Do you have any allergies to medications? YES_____ NO_____
If "yes," list medications: _____

_____

Please list the medications you take regularly, including all pills, eye drops, aspirin products, vitamins, and any herbal or homeopathic products.

MEDICATION **STRENGTH** **HOW MANY TIMES A DAY?**

_____

_____

_____

_____

_____

Date, Initial
UPDATED MEDICAL HISTORY

Reviewed ROS/PMH	Change	Condition Resolved

Date, Initial
UPDATED MEDICATION LIST

Reviewed Meds.	Change	D/C'd

Do you smoke? YES_____ NO_____ If you smoke, how many packs per day? _____
How long have you smoked? _____
If you don't smoke now, have you smoked in the past? YES_____ NO_____
How many years?_____
How many packs per day? _____ When did you stop? _____

Do you drink alcohol? YES_____ NO_____
If "yes," how much do you drink each day? _____
Have your drinking habits changed over the years? YES_____ NO_____

SOCIAL HISTORY

Current occupation (or former, if retired) _____
Do you drive? YES_____ NO_____
Do you live alone? YES_____ NO_____

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			

SKIN

Rash	YES	NO

CARDIOVASCULAR

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

PSYCHIATRIC

Depression	YES	NO	Anxiety	YES	NO

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

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.

Disease			**Relationship to Patient**
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 understand that it is my responsibility to check with my insurance company to verify what my policy may or may not cover.

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 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. 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 co-pay 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 a $15.00 service fee for any copayment not paid at the time of service.
6. To pay for any returned check fees incurred by TECG.
7. If I am the parent/guardian bringing in a child for treatment, that I am responsible for all fees incurred by the child.
8. To pay collection expenses and attorney's fees if my account is sent to the collection agency or an attorney for collection.
9. To pay for my refraction expense if my insurance does not cover.

Date: _____ Signature: _____