

EYECARE ASSOCIATES OF SEVIER COUNTY

DATE _____

PATIENT REGISTRATION INFORMATION

Welcome to our office! Thank you for choosing our office for your eye care. Please take the time to complete this form accurately and completely. It helps us do the best job possible for you. This information is held in complete confidence as it is part of your permanent record, and will not be released to anyone unless you authorize its release in writing.

Preferred Salutation

Dr. Mr. Mrs. Ms. Miss Reverend Other: _____

Last First Preferred Name Birth Date Age

Social Security Number Marital Status Spouse's Name

Mailing Address City State Zip Code

Residence Phone Business Phone Extension Employer Occupation

Responsible Party (if different than above) Address City State Zip Code

How did you hear about us? Date of Last Eye Exam Previous Eye Doctor (City & State also)

INSURANCE INFORMATION

We REQUIRE all insurance information prior to services being provided. Due to the diverse nature of many eye conditions, disorders, and procedures, many of the services we provide are covered by your MAJOR MEDICAL INSURANCE rather than routine vision coverage. Please provide us with the following information even if you believe that you are seeing us for a nonmedical reason. We also require your PRIMARY CARE PHYSICIAN'S NAME & PHONE NUMBER.

MEDICAL INSURANCE COMPANY Policy Holder SS# Primary Care Physician Phone

VISION INSURANCE COMPANY Policy Holder SS# Policy # Group #

FINANCIAL POLICY INFORMATION

Please indicate method of payment: () Cash/Check () Visa/Master Card

**ALL CO-PAYMENTS AND INDIVIDUAL PORTIONS OF YOUR BALANCE
ARE DUE AT THE TIME OF SERVICE.**

I authorize the release of any medical or other information necessary to process any claims arising from services and materials provided. I also request payment of government or private insurance benefits to the physician accepting assignment for services and materials provided. I also understand that I assume all financial responsibility for this account for any amounts due, regardless of insurance coverage.

Signature Date Relationship to Patient

ABOUT YOUR EYES

What specific problem with your eyes, if any, brought you to our office? Please Explain: _____

Do you frequently experience/have (check all that apply):

- | | | |
|---|--|---|
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Painful Eyes | <input type="checkbox"/> Seeing Rings Around Lights |
| <input type="checkbox"/> Distorted Vision | <input type="checkbox"/> Gritty, Sandy Eyes | <input type="checkbox"/> Color Vision Difficulties |
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Aching Eyes | <input type="checkbox"/> Distance Judgement Problem |
| <input type="checkbox"/> Tired Eyes | <input type="checkbox"/> Drawing/Pulling | <input type="checkbox"/> School Difficulties |
| <input type="checkbox"/> Red Eyes | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Losing Place While Reading |
| <input type="checkbox"/> Watery Eyes | <input type="checkbox"/> Headaches | <input type="checkbox"/> Night Vision Problems |
| <input type="checkbox"/> Itchy Eyes | <input type="checkbox"/> Excessive Blinking | <input type="checkbox"/> Extreme Light Sensitivity |
| <input type="checkbox"/> Burning Eyes | <input type="checkbox"/> Excessive Squinting | <input type="checkbox"/> Discharge from eyes |
| <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Seeing Spots/Dots | <input type="checkbox"/> Other: _____ |

Do you presently wear or have been prescribed glasses? Yes No If so, how often? _____
Do you presently wear contacts? Yes No If so, what type? _____ Extended Wear Daily Wear Soft Rigid

Do you currently use any drops or medication for your eyes? Yes No If so, please list: _____

If you or a blood relative have experienced any of the following, check all that apply and indicate who:

- | | | |
|---|--|--|
| <input type="checkbox"/> Eye Injury | <input type="checkbox"/> Eye Operation | <input type="checkbox"/> Turned or Crossed Eye |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Eye Disease | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Amblyopia/Lazy Eye | <input type="checkbox"/> Blindness | <input type="checkbox"/> Other: _____ |

Does your job require the use of a computer? Yes No How many hours per day? _____

Additional Notes: _____

ABOUT YOUR GENERAL HEALTH

How would you describe your general health: Excellent Average Poor

When was your last physical examination? _____ Physician's name _____

If you or a blood relative have any of the following, check all that apply and indicate who:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Epilepsy or Convulsions |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Problems | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Sexually Transmitted Disease | |

Are you presently or have you recently been taking any prescription or non-prescription medications? Please list them: _____

Do you have any allergies or are you allergic to any medications? Please list them: _____

Female patients, if you are currently taking oral contraceptives or hormonal supplements, please indicate length of Rx history: _____

If you are pregnant, please indicate how many months: _____

Additional Notes: _____