

PRIMARY EYE CARE ASSOCIATES OD, PA

PATIENT INFORMATION

DATE: _____ REFERRED BY: _____
NAME _____ AGE: _____
MAILING ADDRESS: _____ DOB: _____
PHYSICAL ADDRESS: _____
CITY: _____ ST: _____ ZIP _____ RACE: _____
HOME PHONE: _____ WORK PHONE: _____ CELL: _____
SOCIAL SECURITY NUMBER: _____ SEX: M F MARITAL STATUS: S M W D
OCCUPATION: _____ EMPLOYER: _____
EMERGENCY CONTACT: _____

INSURANCE INFORMATION

HEALTH INSURANCE: _____ MEMBER NAME: _____
RELATIONSHIP TO PATIENT: _____ MEMBER DOB: _____
VISION INSURANCE: _____ MEMBER SS#: _____

EYE HEALTH HISTORY

DATE LAST EXAM: _____ NAME OF DOCTOR _____
DO YOU WEAR GLASSES: YES NO CIRCLE ALL THAT APPLY: ALL THE TIME READING DRIVING TV
DO YOU WEAR CONTACTS: YES NO BRAND: _____ HOURS/DAY: _____
HOW OFTEN DO YOU CHANGE CONTACTS? _____
DESCRIBE ANY PROBLEMS WITH YOUR CONTACTS: _____

BLOODSHOT EYES	Y N	GLAUCOMA	Y N
BLURRY VISION-NEAR	Y N	HEADACHES	Y N
BLURRY VISION-DISTANCE	Y N	ITCHING EYES	Y N
BURNING EYES	Y N	LAZY EYE	Y N
CATARACTS	Y N	LIGHT SENSITIVE	Y N
COLOR VISION, POOR	Y N	LOSS OF VISION	Y N
CROSSED EYES	Y N	MACULAR DEGENERATION	Y N
DISCHARGE FROM EYES	Y N	MIGRAINE HEADACHES	Y N
DIZZY SPELLS	Y N	NIGHT VISION, POOR	Y N
DOUBLE VISION	Y N	RED EYES	Y N
DRY EYES	Y N	SEEING HALOS	Y N
EYE INFECTION	Y N	SEEING FLASHES	Y N
EYE INJURY	Y N	TEMPORARY LOSS/VISION	Y N
EYE STRAIN	Y N	TWITCHING EYELID	Y N
FLOATERS/SPOTS	Y N	WATERING EYES	Y N

PLEASE DESCRIBE ANY EYE SURGERY YOU HAVE HAD: _____

CONTINUE ON OTHER SIDE

HEALTH HISTORY

	<u>YOU</u>	<u>FAMILY</u>		<u>YOU</u>	
<u>FAMILY</u>					
AIDS/HIV	Y N	Y N	FIBROMYALGIA	Y N	Y N
ARTHRITIS	Y N	Y N	GLAUCOMA	Y N	Y N
ARTIFICIAL HEART VALVE	Y N	Y N	HAY FEVER	Y N	Y N
ARTIFICIAL JOINTS	Y N	Y N	HEART	Y N	Y N
ASTHMA/BREATHING	Y N	Y N	HEPATITIS	Y N	Y N
BLEEDING	Y N	Y N	KIDNEY DISEASE	Y N	Y N
BLINDNESS	Y N	Y N	LUPUS	Y N	Y N
BLOOD PRESSURE	Y N	Y N	MIGRAINE	Y N	Y N
CANCER	Y N	Y N	MUSCLE WEAKNESS	Y N	Y N
CHEMICAL DEPENDENCY	Y N	Y N	NEUROLOGICAL	Y N	Y N
DEPRESSION	Y N	Y N	POOR COLOR VISION		Y N
Y N					
DIABETES	Y N	Y N	PSYCHIATRIC	Y N	Y N
DIGESTIVE	Y N	Y N	RETINAL DISEASE	Y N	Y N
DRUG SENSITIVITY	Y N	Y N	RHEUMATIC FEVER	Y N	Y N
EAR/NOSE/THROAT	Y N	Y N	SHINGLES	Y N	Y N
EMPHYSEMA	Y N	Y N	SKIN CONDITIONS	Y N	Y N
EPILEPSY	Y N	Y N	STROKE	Y N	Y N
FAINTING SPELLS	Y N	Y N	THYROID CONDITIONS	Y N	Y N
FATIGUE	Y N	Y N	TUBERCULOSIS	Y N	Y N

IF YES TO ANY OF ABOVE, PLEASE EXPLAIN: _____

ARE YOU PREGNANT? Y N
 TOBACCO USE - Y N PACKS PER DAY: _____ ALCOHOL USE - Y N DRINKS PER WEEK? _____
 DO YOU LIVE ALONE? Y N

MEDICATIONS/ALLERGIES

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

PLEASE LIST ANY ALLERGIES TO MEDICATIONS OR OTHER SUBSTANCES:

I understand that, regardless of what insurance I have, I (the responsible party) am ultimately responsible for my bill. My insurance is filed as a courtesy by Primary Eye Care Associates, OD, PA. Primary Eye Care only files to insurance companies that they are providers for. All co-payments and deductibles should be paid at the time of service.
 Signature of responsible party: _____