



WELCOME

Thank you for choosing The Eagleville Eye Clinic for your eyecare needs. Please take a few minutes to fill out this form as completely as you can.

PATIENT INFORMATION

Name _____ Date _____
First Middle Initial Last

Preferred name/nickname: _____

Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Cell Phone (_____) _____

Please circle which number you prefer us to use when calling you: Home Cell Work

E-mail address _____

May we contact you by e-mail regarding appointments, account information, or practice news? Yes No

Sex M F Age _____ Birthdate _____ Patient SS # _____

Married Widowed Single Minor Separated Divorced

Spouse or Parent/Guardian _____ Phone (_____) _____

Patient Employer/School _____ Phone (_____) _____

Person to contact in case of emergency _____ Phone (_____) _____

***How did you hear about us? _____

PAYMENT AGREEMENT / INSURANCE AUTHORIZATION

Name of person responsible for this account _____

Relationship to patient _____ Phone(_____) _____

How will payment be made for today's visit? (Please circle one) Cash Check Credit Card Insurance Other

Name of Insured Person _____ Date of Birth _____

We will be glad to file your insurance for today's visit. However, we cannot guarantee payment.

I certify that I, and/or my dependent(s), have insurance coverage with _____, and assign directly to **Dr. Rena R. Cron** all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance**, including all collection costs and legal fees for unpaid balances. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent, Guardian or Personal Representative

Date

EYE HEALTH HISTORY

What is the reason for today's visit? _____

Do you currently experience any of the following:

- | | | |
|---|--|---|
| <input type="checkbox"/> poor distance vision | <input type="checkbox"/> light sensitivity | <input type="checkbox"/> bloodshot/red eyes |
| <input type="checkbox"/> poor near vision | <input type="checkbox"/> twitching eyelid | <input type="checkbox"/> dry eyes |
| <input type="checkbox"/> poor night vision | <input type="checkbox"/> light flashes | <input type="checkbox"/> watering eyes |
| <input type="checkbox"/> poor color vision | <input type="checkbox"/> burning/ itching eyes | <input type="checkbox"/> floaters or spots |
| <input type="checkbox"/> frequent headaches | <input type="checkbox"/> discharge from eyes | <input type="checkbox"/> double vision |
| <input type="checkbox"/> eyestrain | <input type="checkbox"/> eye infection/injury | <input type="checkbox"/> temporary loss of vision |
| <input type="checkbox"/> glare problems | <input type="checkbox"/> migraine headaches | |

Have you or a relative ever had any of the following:

- | Yourself | Relative | Yourself | Relative |
|--------------------------|---|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> cataracts | <input type="checkbox"/> | <input type="checkbox"/> crossed or turning eye |
| <input type="checkbox"/> | <input type="checkbox"/> retinal disease/detachment | <input type="checkbox"/> | <input type="checkbox"/> lazy eye |
| <input type="checkbox"/> | <input type="checkbox"/> glaucoma | <input type="checkbox"/> | <input type="checkbox"/> blindness |
| <input type="checkbox"/> | <input type="checkbox"/> macular degeneration | <input type="checkbox"/> | <input type="checkbox"/> eye surgery |
| <input type="checkbox"/> | <input type="checkbox"/> other _____ | <input type="checkbox"/> | <input type="checkbox"/> Hay Fever/ Allergies |

HEALTH HISTORY

Physician's Name & Phone # _____ Date Last Seen _____

Place a mark in the box to indicate if you or a blood relative has had any of the following problems:

- | Yourself | Relative | Yourself | Relative |
|--------------------------|--|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Diabetes | <input type="checkbox"/> | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> Thyroid Conditions |
| <input type="checkbox"/> | <input type="checkbox"/> Stroke | <input type="checkbox"/> | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> Heart Condition/disease | <input type="checkbox"/> | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> | <input type="checkbox"/> Skin Conditions |
| <input type="checkbox"/> | <input type="checkbox"/> Asthma | <input type="checkbox"/> | <input type="checkbox"/> Epilepsy/seizure disorder |
| <input type="checkbox"/> | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> | <input type="checkbox"/> Chemical dependency |
| <input type="checkbox"/> | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> | <input type="checkbox"/> AIDS/HIV |
| <input type="checkbox"/> | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> Other _____ |

Are you pregnant? Y N

Tobacco use? Y N

Alcohol use? Y N

MEDICATIONS

List medications you are currently taking, including eye drops: _____

ALLERGIES

List your allergies to medications or other substances: _____

LIFE STYLE QUESTIONNAIRE

Approximate Date of your Last Eye Exam _____

Previous Eye Doctor's Name or Location _____

Do you currently wear eyeglasses? Yes No

If so how often?

All the time Occasionally Reading Driving TV Computer

Are your current glasses: Scratched or broken? Yes No Poorly fitting? Yes No

Out of fashion? Yes No

Do you participate in Sports? Yes No If yes, which sports? _____

Hobbies? Yes No If yes, briefly list hobbies. _____

Do you frequently work outdoors? Yes No

Do you currently wear contacts? Yes No If yes, do you desire new contacts today? Yes No
(check all that apply)

Daily wear Extended wear Disposables Monthly Replacement

Contacts for Astigmatism Multifocals Monovision Cosmetically Tinted

If No, are you interested in trying contacts? Yes No

Do you work at a computer? Yes No

If yes, how many hours per day on average _____

Are you interested in Refractive Surgery to correct your eye sight? Yes No

Are you interested in New Glasses? Yes No New Sunwear? Yes No

ACKNOWLEDGEMENT OF PRIVACY POLICY AND PRACTICES

I understand that in an attempt to protect the privacy of my identifiable health information, the Eagleville Eye Clinic has established a *Privacy Policy* and guidelines for *Privacy Practices* within this office. This information details the use and/or disclosure of information contained in my personal medical/optometric records kept for the purposes of diagnosis, treatment, payment and health care operations. In accordance with HIPAA Regulations, a copy of the Privacy Policy & Practices has been made available to me while in the office today. Should I choose to have a personal copy, one will be given to me at no charge.

() I have read, understand and acknowledge the Privacy Policy and Practices of the Eagleville Eye Clinic.

() I have elected NOT to read the Privacy Policy & Practices of the Eagleville Eye Clinic.

() A copy of the Privacy Policy & Practices was given to me today.

Signature

Today's date

Rev 3/10