Eagleville EYE CLINIC

WELCOME TO OUR OFFICE

Patient Information

Today's Date: _____

Last Name: _____

First Name: _____ MI: ___

Preferred name/nickname:_____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Cell Phone: _____

Gender: M F Date of Birth: _____

Patient SSN: _____

Marital Status: _____

Employer: _____

Occupation: _____

Email: _____

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

Lifestyle Questions

Are you interested in a contact lens evaluation today?
(Additional fees apply.)

❑ Yes ❑ No ❑ Maybe

Do you…? (Check all that apply)

❑… wear prescription glasses?
- If so, how often_____

❑… wear prescription or non-prescription sunglasses?

❑… have "back up" prescription eyewear?

❑… wear contact lenses?

If so, what type? (circle all)

Daily wear Disposable Monthly Replacemnt Hard/Gas Perm

❑… experience discomfort with your contacts?

❑… work at a computer? _____ hrs/day

❑… want information on LASIK or refractive surgery?

❑… have children?

What are your hobbies? _____

_____

_____

How did you find out about our office?

Where have you seen us? *(Check all that apply.)*

❑ Insurance List
❑ Website/Internet
❑ Drive by
❑ Friend/Family:_____
❑ Other: _____
❑ Social Media
❑ Advertisement

Patient Eye History

What specific problems do you have with your vision, eyes, glasses, or contact lenses?

_____

_____

Date of Last Eye Exam: _____

Previous Eye Doctor: _____

Have you ever experienced the following?

(Check all that apply.)	**Currently**	**In the Past**
Blurry Vision without glasses	❑	❑
Blurry Vision with glasses	❑	❑
Vision Loss	❑	❑
Headaches	❑	❑
Double Vision	❑	❑
Floaters/ Spots	❑	❑
Flashes of light	❑	❑
Color Blindness	❑	❑
Sensitivity to light	❑	❑
Eye Fatigue/ Tired Eyes	❑	❑
Pain/ Irritation	❑	❑
Dry Eye	❑	❑
Red Eye	❑	❑
Itchy/ Burning eyes	❑	❑
Eyelid Problems	❑	❑
Watery Eyes	❑	❑
"Lazy Eye"/ Amblyopia	❑	❑
Eye turn/Crossed eye	❑	❑
Eye Injury/ Trauma/Abrasion	❑	❑
Eye Infections	❑	❑
Allergy	❑	❑

Other eye problems: _____

Please turn over. Thank you. Rev 11/13

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Primary Physician: _____

Location: _____

Date of Last Physical Exam: _____

CURRENT MEDICATIONS (Rx or Over-the-Counter):
(*List all medications including eye drops, vitamins, etc.*)

_____

_____

Allergies to medications? ❑ Yes ❑ No

If so, what medications? _____

_____

Have you had any surgeries? ❑ Yes ❑ No

If so, please describe: _____

_____

Is there a possibility that you are pregnant? ❑ Yes ❑ No

Tobacco: ❑ None ❑ Former Smoker ❑ < 1 pack/day
❑ 1-2 packs/day ❑ >2 packs/day

Alcohol: ❑ None ❑ Social drinker
❑ 1-2 drinks/day ❑ Above Average Use

Narcotics/ Drugs: ❑ None ❑ Recreational

Have you ever been diagnosed or treated for the following health problems?

- ❑ Allergies
- ❑ High Blood Pressure
- ❑ Diabetes
- ❑ Cholesterol
- ❑ Cardiovascular
- ❑ Anemia
- ❑ Headaches/Migraines
- ❑ Sinus Problems
- ❑ Endocrine
- ❑ Digestive
- ❑ Kidney problems
- ❑ Reproductive
- ❑ Genitourinary
- ❑ Multiple Sclerosis
- ❑ HIV/AIDS
- ❑ Shingles
- ❑ Thyroid problems
- ❑ Immune System
- ❑ Stroke
- ❑ Skin/ Eczema/ Rashes
- ❑ Hepatitis
- ❑ Arthritis
- ❑ Muscle/Bone
- ❑ Epilepsy/Seizures
- ❑ Depression
- ❑ Asthma
- ❑ Respiratory/COPD
- ❑ Cancer
- ❑ ADD/ADHD
- ❑ Other Health Problems: _____

_____

THANK YOU!

Family Medical/ Eye History

Have you or a family member been diagnosed with any of the following? Please check all that apply.

	Self	Which family member?
Blindness	❑	❑ _____
Cataracts	❑	❑ _____
Glaucoma	❑	❑ _____
Eye Turn/Crossed eyes	❑	❑ _____
Retinal Problems	❑	❑ _____
Macular Degeneration	❑	❑ _____
Diabetes	❑	❑ _____
Heart Disease	❑	❑ _____

Privacy Practices for Health Information

The Eagleville Eye Clinic has established a *Privacy Policy* and guidelines *for Privacy Practices* within this office. A copy of these policies can be provided to you at your request.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Dr. Rena Cron & the Eagleville Eye Clinic to release any medical or incidental information that may be necessary for medical benefits or to obtain payment for services. This includes but is not limited to vision plans or medical insurances.

CONSENT FOR TREATMENT: I hereby authorize the Eagleville Eye Clinic to administer diagnostic and medical procedures as may be necessary for proper health care.

_____ _____
Patient Signature Date

Additional Testing

To safe-guard the health of your eyes, Dr. Cron may recommend additional diagnostic testing such as digital retinal photographs, extended visual field testing or corneal pachymetry. These diagnostic procedures are in addition to a routine eye exam and may incur additional charges.

PAYMENT AGREEMENT/INSURANCE AUTHORIZATION

How will payment be made for today's visit? (circle)
Cash Check Credit Card Care Credit

We will gladly file your insurance for today's visit.
****However, we cannot guarantee payment.**

I understand that if insurance is filed for vision or medical services, all payments will be assigned directly to Dr. Rena Cron. **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.

Signed: Date: