Bloomington Family Eyecare Center

PATIENT INFORMATION

Name: ____________________ **Social Security #:** ______-______-______

If married, spouse's name: ____________________ **If minor, parent's name:** ____________________

Address: ____________________ **City:** ____________________ **State:** _____ **Zip:** __________

Date of birth: _____/_____/_____ **Home Phone:** ____________________ **Work Phone:** ____________________

Cell Phone: ____________________ **E-Mail Address:** ____________________

Occupation: ____________________ **Employer:** ____________________

How did you hear about our practice? ____________________

Whom may we thank for referring you? ____________________

RESPONSIBLE PARTY

Person responsible for this account: ____________________

Relationship to patient: ____________________ **Home Phone:** ____________ **Work Phone:** ____________

Address: ____________________ **City:** ____________________ **State:** _____ **Zip:** __________

Name Of Employer: ____________________

INSURANCE INFORMATION

While we will do our best to help you obtain maximum benefits, it is your responsibility to know what your plan covers.

Name of Insured: ____________________ **Relationship to patient:** ____________________

Date of birth: _____/_____/_____ **Social Security #:** ______-____-______ **Employer:** ____________________

Vision Insurance Co.: ____________________ **Policy / ID / Group #:** ____________________

Health Insurance Co.: ____________________ **Policy /ID / Group #:** ____________________

◄ ***PAYMENT IS EXPECTED AT TIME OF SERVICE*** ►

Please Indicate Method of Payment

[ ] Cash / Check   [ ] Visa   [ ] MasterCard   [ ] Discover

I authorize the release of any information necessary to process insurance claims. I understand that I am responsible for payment of non-covered services, amounts applied toward my deductible, as well as co-insurance amounts. If my account should become past due and collection efforts become necessary, I understand that I will be held responsible for a 35% collection fee, court costs, and lawyer fees. A 1½% monthly billing charge will be assessed after an account is 30 days past due.

Signature: ____________________ **Date:** ______/______/______

◄***OVER***►

MEDICAL HISTORY

How is your general health? ____________________

Current medications: ____________________

____

Do you have any problems with these systems?

Eyes	Y / N	Musculoskeletal	Y / N
Gastrointestinal	Y / N	Skin	Y / N
Nervous	Y / N	Endocrine (glands)	Y / N
Mental	Y / N	Blood / Lymph	Y / N
Ears/Nose/Throat	Y / N	Urinary	Y / N
Cardiovascular	Y / N	Respiratory	Y / N

Please check all that apply:

[ ] Diabetes Type: ____________ Date of onset: ____________

[ ] Allergies To what: ____________________

[ ] Medication allergies To what: ____________________

[ ] Headaches

[ ] Other health problems ____________________

[ ] Surgeries ____________________

Do you use: [ ] Cigarettes / tobacco [ ] Alcohol [ ] Other substances ____________

Name of family doctor: ____________________

FAMILY HISTORY

[ ] High blood pressure	Relation: ________	[ ] Retinal Detachment	Relation: ________
[ ] Diabetes	Relation: ________	[ ] Cataracts	Relation: ________
[ ] Macular degeneration	Relation: ________	[ ] Glaucoma	Relation: ________
[ ] Other eye or health conditions: ____________			Relation: ________

PERSONAL EYE HISTORY

[ ] Eye surgeries ____________________

[ ] Eye injuries ____________________

[ ] Vision therapy ____________________

[ ] Glaucoma
[ ] Cataracts
[ ] Dry eyes
[ ] Amblyopia (lazy eye)
[ ] Other eye problems: ____________________

Updated: _____/_____/_____ Pt. Initials: _______ Updated: _____/_____/_____ Pt. Initials: _______

Doctor's Initials: ________ Date: _____/_____/_____