EYE CARE *of* EDENTON

Welcome to our office! We want to provide you with the very best in vision care. We realize your time is valuable and our staff will try to attend to you as quickly as possible. In order for us to serve you better, please complete the following data for our records in its entirety. (PLEASE PRINT)

Date: ________________

PATIENT INFORMATION

Title (circle one) Mr. Mrs. Ms. Miss Master Dr. Rev.

Last Name ________________________ Suffix ____ **First Name** ___________________________ Middle Initial ___

Preferred name ____________________________ Gender: M F Marital Status: M S D W O

Mailing Address ____

City ________________________________ State __________ Zip _________________

Social Security # ____ **Date of Birth** _____/_____/ _________

Home # (_____)_________________ Cell # (_____)___________________ Work # (_____)___________________

Email____

Employer: ____________________________________ Occupation:______________________________________

Preferred Language: ____________________ Race: __________________ Ethnicity: ____________________

Whom may we thank for referring you to us? ____

Emergency Contact ____ Phone_____________________________

RESPONSIBLE PARTY ***(If different from the patient, please complete the following.)***

Title (circle one) Mr. Mrs. Ms. Miss Master Dr. Rev.

Last Name ________________________ Suffix ____ First Name ___________________________ Middle Initial ____

Mailing Address ____ City

____ State __________ Zip ____________________ Home #

(_______)__________________ Work # (_______) __________________Email________________________

Social Security # ____ Date of Birth ______/_______/ _________

Payment is expected on the day of your appointment. If filing insurance, you will be responsible for any estimated out of pocket expenses including deductibles, co-insurance, and/or copay. Payment for eyewear and/or contact lens supply is due at the time of ordering. (See additional form for insurance authorization.)

EYE HEALTH HISTORY

Date of last exam: _____________________________Doctor:____

Do you currently wear glasses? Yes No

How old are your glasses? ______________

Do you wear them (circle one):

all the time reading/near work

distance tasks only occasionally

work safety

Have you ever worn contacts? Yes No

Do you currently wear contacts? Yes No

What Brand? ___________________

Are you interested in wearing contact lenses? Y N

How many hours per day do you work on a computer? _________________________

OCULAR HISTORY

Have you ever had an eye injury? Y N Explain:____

Have you ever had eye surgery? Y N Explain: ____

____

History of Eye Disease? (please circle)

Glaucoma Macular Degeneration Cataracts Retinal Detachment Retinopathy Floaters

Flashing Lights Loss of Vision Eye Strain Blurred Vision Other: ____________________________

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Reason for Today's Visit:____
Primary Care Physician: ___________________________

MEDICAL HISTORY

Do you have any drug allergies? Y N Please list:____
Do you take any medications? Y N Please list:____

____

Have you had any medical surgeries? Y N List: ____

____

Are you pregnant or nursing? Y N

SOCIAL HISTORY

Do you drive? Y N
Do you use illegal drugs? Y N
Do you use tobacco products? Y N
How much? _______ How often? __________
Do you drink alcohol? Y N
How much? _______ How often? __________

REVIEW OF SYSTEMS

Do you currently, or have you ever, had any problems in the following areas:

Cardiovascular		
Angina	Yes	No
Chest Pain	Yes	No
Heart Attack	Yes	No
Heart Failure	Yes	No
Hypertension	Yes	No
Constitutional		
Dizziness	Yes	No
Fainting	Yes	No
Fever	Yes	No
Weight Loss/Gain	Yes	No
Endocrine		
Diabetes	Yes	No
Pituitary	Yes	No
Thyroid	Yes	No
Gastrointestinal		
Constipation	Yes	No
Diarrhea	Yes	No
Nausea	Yes	No
Vomiting	Yes	No
Genitourinary		
Cervical Cancer	Yes	No
Kidney Disease	Yes	No
Prostate Cancer	Yes	No
STD	Yes	No
Ear, Nose, Mouth, Throat		
Bleeding gums	Yes	No
Chronic Cough	Yes	No
Dental Disorder	Yes	No
Dry Mouth	Yes	No
Ear Infection	Yes	No
Hearing Loss/Injury	Yes	No
Nose Bleeds	Yes	No
Hematological/Lymphatic		
Anemia	Yes	No
Leukemia	Yes	No
Sickle Cell	Yes	No
Immunologic		
Immune Disorder	Yes	No
Influenza	Yes	No
Integumentary		
Skin Disorder	Yes	No
Skin Cancer	Yes	No
Musculoskeletal		
Arthritis	Yes	No
Joint Pain	Yes	No
Joint swelling	Yes	No
Lupus	Yes	No
Muscle Pain	Yes	No
Stiffness	Yes	No
Neurological		
Headaches	Yes	No
Migraines	Yes	No
Numbness	Yes	No
Paralysis	Yes	No
Seizures	Yes	No
Psychiatric		
ADD	Yes	No
Depression	Yes	No
Insomnia	Yes	No
Memory Loss	Yes	No
Bi-Polar	Yes	No
Respiratory		
Asthma	Yes	No
Emphysema	Yes	No
Shortness of Breath	Yes	No
Tuberculosis	Yes	No

Family Medical History: Please list any medical/ocular disease that runs in your family:
____
____

Financial Responsibility

We will gladly file your insurance for you. It is your responsibility to know what your insurance(s) approves. Prior to your services, contact your insurance(s) to find out about what they do and do not cover, especially if you have both ROUTINE VISION coverage and MEDICAL coverage. Our responsibilities are only to acquire authorization from your insurance(s) if necessary and file your claim. It is not our staffs' responsibility to advise you regarding your coverage.

If you have a medical condition or eye disease, it is likely that your COMPREHENSIVE examination and medical testing may be performed on the same day. The claim for such instances may be split within multiple insurances, if applicable. There are possibilities that you would be responsible for multiple copayments based on your particular plans at time of service. If during your ROUTINE examination, any eye disease(s) or medical condition(s) is discovered that requires further testing, treatment, and/or followup, testing (including, but not limited to, fundus photography, optical coherence tomography, etc.) could be performed on the same day or your will be scheduled for an additional office visit and it will be filed with your MEDICAL insurance(s).

I acknowledge FULL RESPONSIBILITY for services provided to me and authorize my insurance company(s) to remit payment directly to Eye Care of Edenton, PLLC. I permit a copy of this authorization to be used in place of the original.

I understand that once my insurance is filed, upon my request, either with my ROUTINE VISION and/or MEDICAL policy, any co-pays, co-insurances, deductibles, and/or remaining balances are my responsibility. I understand that an estimated out of pocket expenses will be due at the time of service. I understand that once my examination is filed, per my request, it cannot be reversed. I further acknowledge that if any remaining balances are not paid in compliance with Eye Care of Edenton, PLLC's policy, my account will result in the transfer to an outside collection agency.

I authorize the release of any requested medical information on my behalf to the Social Security Administration (if utilizing Medicare), my insurance company(s), and/or any physicians directly involved in my care.

I understand that by signing this document, I have read and understand my responsibilities.

Signature: ______________________________ Date: ______________

Patient Name (if Minor): ____________________ Relationship to Minor: ___________

INSURANCE INFORMATION
(Cards may be attached in lieu, if applicable)

Insurance Company: ________________________
Policy Holder Name: ______________________ Date of Birth ___/____/____
Policy Holder's Social Security # ____________________
Subscriber ID# ______________________ Plan Group # ________
Patient's Relationship to Policy Holder: Self Spouse Child Other: __________

Insurance Company: ________________________
Policy Holder Name: ______________________ Date of Birth ___/____/____
Policy Holder's Social Security # ____________________
Subscriber ID# ______________________ Plan Group # ________
Patient's Relationship to Policy Holder: Self Spouse Child Other: __________

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge the posted Eye Care of Edenton, O.D., P.L.L.C. Notice of Privacy Practices. I further acknowledge that a full printed copy is available upon my request.

Patient Name: ___________________________________ Date: ____________________

Guardian/Signature (if different than patient): ____