

**General Information**

**Suburban Eye Care**

Date: \_\_\_/\_\_\_/\_\_\_

Last Name \_\_\_\_\_ First Name: \_\_\_\_\_ M \_\_\_\_\_  
 DOB: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_  
 M or F SSN: \_\_\_/\_\_\_/\_\_\_ Marital Status: Married / Single / Divorced / Widowed  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Ph: ( ) \_\_\_\_\_ Cell Ph: ( ) \_\_\_\_\_ Work Ph: ( ) \_\_\_\_\_  
 Employer/School: \_\_\_\_\_ Occupation/School Grade: \_\_\_\_\_  
 E-mail Address: \_\_\_\_\_ Sports/Hobbies: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_

**CASE HISTORY / REASON FOR VISIT:**

**Eye Glasses Contact Lenses Vision Therapy Low Vision/Partially Sighted Laser Vision Correction**

Date of Last Medical Exam: \_\_\_/\_\_\_/\_\_\_ Primary Physician/Clinic: \_\_\_\_\_

Date of Last Eye Exam: \_\_\_/\_\_\_/\_\_\_ Clinic/Eye Doctor's Name: \_\_\_\_\_

Do you wear glasses? Yes/No/All the time/Sometimes/Work Only/Reading only/Driving only

How old are your present glasses: \_\_\_\_\_ Do you wear prescription Sun Wear: Yes/No

Do you wear contacts? Yes No Type: \_\_\_\_\_ Solution Used: \_\_\_\_\_

Wearing schedule: **Daily Overnight** Replacement schedule: **Daily 2 week Monthly Yearly**

Do you work on a computer? **Yes No** If so, how many hours? \_\_\_\_\_ Are your eyes comfortable? **Yes No**

Have you ever had eye injuries? Yes No Which Eye? \_\_\_\_\_

Have you ever had eye surgeries? Yes No Why? \_\_\_\_\_

Have you used eye medication? Yes No Why? \_\_\_\_\_

Are you currently pregnant or nursing? Yes No N/A

**Have you ever been diagnosed with?**

Cataracts: Yes/No When were you diagnosed? \_\_\_\_\_

Glaucoma: Yes/No When were you diagnosed? \_\_\_\_\_

Macular Degeneration: Yes/No When were you diagnosed? \_\_\_\_\_

**What are your visual symptoms: Please circle any that apply:**

**Please indicate Right, Left or Both, along with severity 1(Low) 2 (Moderate) 3 (High)**

- |                             |     |                       |     |                          |     |
|-----------------------------|-----|-----------------------|-----|--------------------------|-----|
| [ ] Blurred Vision/Distance | RLB | [ ] Dry Eyes          | RLB | [ ] Headaches            | RLB |
| [ ] Blurred Vision/Near     | RLB | [ ] Red Eyes          | RLB | [ ] Migraine Headaches   | RLB |
| [ ] Double Vision           | RLB | [ ] Watery Eyes       | RLB | [ ] Loss of Vision       | RLB |
| [ ] Eye Strain              | RLB | [ ] Wandering eye     | RLB | [ ] Crossed Eyes         | RLB |
| [ ] Eye Infections          | RLB | [ ] Mucus Discharge   | RLB | [ ] Light Sensitive      | RLB |
| [ ] Eye Pain/Soreness       | RLB | [ ] Floaters or Spots | RLB | [ ] Sandy/Gritty Feeling | RLB |
| [ ] Tired eyes              | RLB | [ ] See Flashes       | RLB | [ ] Poor Color Vision    | RLB |
| [ ] Burning Eyes            | RLB | [ ] See Halos         | RLB | [ ] Droopy Lid           | RLB |
| [ ] Itchy Eyes              | RLB | [ ] Poor Night Vision | RLB |                          |     |

**\*Please turn over and complete other side\***

**PERSONAL MEDICAL HISTORY ( REVIEW OF SYSTEMS ) : PLEASE CHECK IF ANY OF THE FOLLOWING APPLIES TO YOU, AND LIST ANY MEDICATIONS FOR EACH CONDITION THAT YOU CHECK. IF YOU HAVE NONE OF THESE CONDITIONS, PLEASE CHECK NONE.**

<b>Cardiovascular:</b> __ None <input type="checkbox"/> Hypertension <input type="checkbox"/> Stroke <input type="checkbox"/> Heart Disease <input type="checkbox"/> Vascular Disease <input type="checkbox"/> Other:	<b>Endocrine:</b> __ None <input type="checkbox"/> Non-Insulin Dependent Diabetes <input type="checkbox"/> Insulin Dependent Diabetes <input type="checkbox"/> Thyroid Problem <input type="checkbox"/> Hormonal Dysfunction <input type="checkbox"/> Other:	<b>Respiratory:</b> __ None <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> COPD <input type="checkbox"/> Other:
<b>Constitutional:</b> __ None <input type="checkbox"/> Cancer <input type="checkbox"/> Trauma/Large Volume Blood Loss <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Other:	<b>Ocular</b> __ None <input type="checkbox"/> Glaucoma <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> Detached Retina <input type="checkbox"/> Other:	<b>Psychiatric:</b> __ None <input type="checkbox"/> ADHD <input type="checkbox"/> Depression <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other:
<b>Neurological:</b> __ None <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Epilepsy <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Tumor <input type="checkbox"/> Other:	<b>Musculoskeletal:</b> __ None <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Ankylosing Spondylitis <input type="checkbox"/> Other:	<b>Immunologic:</b> __ None <input type="checkbox"/> AIDS or HIV <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Lupus <input type="checkbox"/> Neurofibromatosis <input type="checkbox"/> Other:
<b>Hematological:</b> __ None <input type="checkbox"/> Anemia <input type="checkbox"/> Leukemia <input type="checkbox"/> Other:	<b>Gastrointestinal</b> __ None <input type="checkbox"/> Crohn's <input type="checkbox"/> Colitis <input type="checkbox"/> Other:	<b>Ear/Nose/Throat:</b> __ None <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Upper Respiratory Infection <input type="checkbox"/> Other:
<b>Dermatologic:</b> __ None <input type="checkbox"/> Eczema <input type="checkbox"/> Rosacea <input type="checkbox"/> Psoriasis <input type="checkbox"/> Other:	<b>Allergies (please list)</b> __ None Drug:  Environmental:	<b>Alcohol Use:</b> Y    N Amount:  <b>Tobacco Use:</b> Y    N Amount:

Please list physical reaction's to above allergies: \_\_\_\_\_

Please list any medications and/or drugs that you are taking (including herbal) :

See Attached List: \_\_\_\_\_

1                                   For \_\_\_\_\_  
 2                                   For \_\_\_\_\_  
 3                                   For \_\_\_\_\_  
 4                                   For \_\_\_\_\_  
 5                                   For \_\_\_\_\_

6                                   For \_\_\_\_\_  
 7                                   For \_\_\_\_\_  
 8                                   For \_\_\_\_\_  
 9                                   For \_\_\_\_\_  
 10                                  For \_\_\_\_\_

**FAMILY HISTORY: Has anyone in your family (grandparents, parents, siblings, children, living or deceased) been diagnosed with:**

**DISEASE / CONDITION**

Retinal Detachment: Yes/No \_\_\_\_\_  
 High Blood Pressure: Yes/No \_\_\_\_\_  
 Diabetes: Yes/No \_\_\_\_\_  
 Cancer: Yes/No \_\_\_\_\_  
 Heart Disease: Yes/No \_\_\_\_\_  
 Thyroid Disease: Yes/No \_\_\_\_\_

Blindness: Yes/No \_\_\_\_\_  
 Cataracts: Yes/No \_\_\_\_\_  
 Glaucoma: Yes/No \_\_\_\_\_  
 Crossed Eyes: Yes/No \_\_\_\_\_  
 Macular Degeneration: Yes/No \_\_\_\_\_  
 Lupus: Yes/No \_\_\_\_\_

Reviewed by:

Dr \_\_\_\_\_

Date \_\_\_\_\_

# Suburban Eye Care, P.C.

## Patient Financial Information Sheet

I understand that payment in full is due at time of service unless other arrangements have been made. All fees for all services & materials provided are the responsibility of the patient or account responsible party as completed on the general information form.

Name of Patient: \_\_\_\_\_ DOB \_\_\_\_\_

Name of Insured: \_\_\_\_\_ DOB \_\_\_\_\_

If No Insurance Card is Available please supply the Insurance Carrier and ID #

Name of Insurance Carrier: \_\_\_\_\_

Policy#: \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance Card Copied: \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ No Card

### Authorization and Release:

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. Any portion not paid by the insurance company is the patient's responsibility.

I authorize the release of any information including the diagnosis and the records of any treatment or examinations rendered to me or my child to: \_\_\_\_\_

\_\_\_\_\_  
Signature of patient or parent if minor

\_\_\_\_\_  
Date

### HIPAA Privacy Practice Acknowledgement

I have received or was offered and declined a notice of privacy practices.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please fill out the form and return to receptionist.  
This information is required by the insurance companies and HIPPA.

Name: \_\_\_\_\_

State where you were born: \_\_\_\_\_

The listed address is  
(please circle one): Mailing Address

Current Address

Preference of communication: Home Phone  
Email

Cell Phone  
U.S. mail

Work Phone

Race  
(please circle one): American/Alaskan Native  
Native Hawaiian

Asian  
Caucasian

African American  
Other \_\_\_\_\_

Ethnicity  
(please circle one): Hispanic/Latino

Not Hispanic/Latino

Primary Language You Speak: English  
Arabic

Spanish  
Other \_\_\_\_\_

French

Mother's Maiden Name  
(for security purposes): \_\_\_\_\_

