



Welcome To Our Office

PATIENT INFORMATION

Name (Last, First, Middle) _____

Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Yes, it is ok to leave me detailed messages regarding my exam and account on my phone: YES / NO

Email _____

Birth Date _____ Age _____ SS# _____

M _____ F _____ Single _____ Married _____ Other _____ Race / Ethnicity _____

Primary Care Physician _____ Preferred Language English Other _____

Who may we thank for your referral? _____

PERSON RESPONSIBLE FOR BILLING (if same as above, check)

Name (Last, First, Middle) _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Other _____ Email _____

Birth Date _____ Age _____ SS# _____

INSURANCE INFORMATION

Vision Insurance _____ ID# _____ Group# _____

Name of Insured _____ Birth Date _____

Medical Insurance _____ ID# _____ Group# _____

Name of Insured _____ Birth Date _____

For patients 18 and older: The following people can have access to my account & health information:

Please read the following and sign below:

- PRIVACY PRACTICES: I have read and understand the Evergreen Eye Care privacy policy (HIPAA Notice).
- We will bill your insurance as a courtesy to you. If your insurance pays less than expected, the balance is your responsibility.
- If collection actions become necessary, I will pay all costs of collection and/or attorney fees in addition to the amount owed.
- ASSIGNMENT and RELEASE: I request that payment from my insurance company, if applicable, be made on my behalf to my providing doctor. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Signature (of Responsible Party) _____ **Date** _____

VISION HISTORY

Do you utilize a computer? NO YES Occupation _____

Do you ever experience dry eyes? NO YES Employer _____

What hobbies do you enjoy? _____

Are you interested in learning about LASIK (refractive surgery)? NO YES

Do you currently wear glasses? NO YES Do you currently wear contact lenses? NO YES

If you could change one thing about your current lenses, what would it be? _____

HEALTH HISTORY

Please list any medications you take & the reason for taking them: _____

Are you allergic to any medications? _____

Do **you currently** have any problems in the following areas? If "yes", please explain:

NO **YES**
Eye Conditions / Surgery _____
(refractive surgery, cataract surgery, glaucoma, diabetic retinopathy, macular degeneration, other)

General Constitution
(fever, weight loss, other)

Allergy/Immunologic
(hay fever, lupus)

Blood / Lymph
(high cholesterol, anemia)

Cardiovascular
(blood vessel condition, heart disease)

Ears, Nose, Throat
(cold, sinus, cough)

Endocrine
(diabetes, thyroid)

Gastrointestinal
(ulcers, intestinal disease)

Genital
(kidney disease, bladder)

Neurological
(Multiple Sclerosis, seizures, stroke)

Psychiatric
(anxiety, depression)

Respiratory
(asthma, COPD, emphysema)

Skin
(rosacea, skin cancer)

Does anyone in your **family** have a history of:

Diabetes

Glaucoma

Macular Degeneration

How often do you use the following:

Alcohol _____

Cigarettes _____

Other Substances _____

Thank you for taking the time to fill out this form.