

Primary Card Holder Name \_\_\_\_\_

Insurance Company \_\_\_\_\_

SS #: Policy Holder \_\_\_\_\_

Primary Cardholder Birthdate \_\_\_\_\_

**Assignment of Benefits:**

I authorize payment of medical benefits directly to Premier Eye Care and Surgery, LTD. The office will file all claims on my behalf to my Primary Insurance Company. If, however, my insurance company refuses payment for any reason, I will be financially responsible for any balances.

**REFRACTION FEE:** Insurance companies do not pay for "refractions." Refraction is the measure of your eye's focusing power; it is the prescription of your glasses. Premier Eye Care charges \$25 for a refraction (due at the time of service) once per calendar year. If you return during the same year and **REQUEST** a new glasses prescription, you will incur this \$25 fee once again.

**APPOINTMENT POLICY:** As a courtesy to our patients, we try to call 48 hours ahead to remind you of your scheduled appointment. However, due to the increased volume of missed appointments, we will now assess a \$50 fee to those patients failing to call to cancel their appointment with the Doctor. This fee will be payable before seeing the Doctor on a subsequent visit.

Signature \_\_\_\_\_

In Case of Emergency Contact & Phone # \_\_\_\_\_

Date _____			
Patient's Name _____			
Mailing Address _____			
City _____	State _____	Zip Code _____	
E-Mail _____			
Home Phone _____			
Cell Phone _____			
Work Phone _____			
SS# Patient _____			
Birthdate _____	Age _____	Sex _____	Marital Status _____
Family Physician (or Pediatrician) _____			
Address _____		Zip Code _____	
Phone _____			
Other Physician(s) who should receive a report (please give name, specialty, address, and phone): _____ _____ _____			

Were you referred to us by your family physician (or pediatrician)?  Yes  No  
 If "no", who referred you, or how did you hear of us?

Please Check One:  
 I have no allergies to medication  
 I have allergies (list on back)

**Reason for Visit:**  Annual Exam  Glaucoma Check  Laser Vision Correction

**Please answer the questions on the other side of this page!**



**Page 2: Medical and Family History**  
**Please check either yes or no for each of the following questions:**

**Eye Problems:** Has the patient had any of the following?

**Yes No**

- Glasses
- Contacts
- Lasik/PRK
- Patching

**Yes No**

- Eye injury if yes when \_\_\_\_\_
- Eye surgery
- Other eye problems:
- Allergy to thimerasol

**Recent Symptoms:**

**Yes No**

- |   |                 |
|---|-----------------|
| <input type="checkbox"/> <input type="checkbox"/> Crossed or wandering eye      | How long? _____ |
| <input type="checkbox"/> <input type="checkbox"/> Excessive squinting           | _____           |
| <input type="checkbox"/> <input type="checkbox"/> Double vision                 | _____           |
| <input type="checkbox"/> <input type="checkbox"/> Excessive eye rubbing         | _____           |
| <input type="checkbox"/> <input type="checkbox"/> Frequent tearing or discharge | _____           |
| <input type="checkbox"/> <input type="checkbox"/> Blurred vision                | _____           |
| <input type="checkbox"/> <input type="checkbox"/> Light sensitivity             | _____           |

**Yes No**

- |   |                 |
|---|-----------------|
| <input type="checkbox"/> <input type="checkbox"/> Frequent headaches                      | How long? _____ |
| <input type="checkbox"/> <input type="checkbox"/> Tired eyes when reading                 | _____           |
| <input type="checkbox"/> <input type="checkbox"/> Weakness or numbness                    | _____           |
| <input type="checkbox"/> <input type="checkbox"/> Clumsiness or bumping into things       | _____           |
| <input type="checkbox"/> <input type="checkbox"/> Can't make normal eye contact           | _____           |
| <input type="checkbox"/> <input type="checkbox"/> Change in performance in school or work | _____           |
| <input type="checkbox"/> <input type="checkbox"/> Other symptoms not mentioned above:     | _____           |

List any allergies

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List any medications the patient is taking, including eye drops:

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List any health problems (or history of ) and any hospitalizations:

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**Pediatric ophthalmology patients only**

**Birth history**

Birth weight: \_\_\_\_\_ lb, \_\_\_\_\_ oz.

**Yes No** (if "yes", what was the problem?)

- Problems during pregnancy
- Problems during delivery or forceps delivery
- Cesarean section

**Yes No** (if "yes", why?)

- Delivered more than 2 weeks early or late
- Baby kept in hospital due to illness
- Delayed development

**Family History:** Is there a family history of:

**Yes No**

- Diabetes
- Cataracts
- Glaucoma
- Macular Degeneration
- Blindness
- Thyroid
- Heart Condition
- High Blood Pressure

**Yes No**

- Cancer
- Amblyopia ("lazy eye")
- Strabismus ("crossed eye")
- Patching treatment
- Eye muscle surgery
- Glasses before age 6
- Cataracts/Glaucoma in childhood
- Allergies