

Primary Card Holder Name _____

Insurance Company _____

HMO PPO OTHER

Card Holder Date of Birth/Phone # _____

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 \$60 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 \$60 fee once again.

APPOINTMENT POLICY: As a courtesy to our patients, we will try to contact you prior to your scheduled appointment. However, due to the increased volume of missed appointments, we will now assess a \$75 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.

MINOR POLICY: In order to protect the safety of our patients, any patient 18 years old or younger must be accompanied by a parent or guardian if a dilated eye exam is required (involving drops to enlarge the pupil which temporarily blurs the vision). New patients 18 years old or younger must be accompanied by a parent or guardian for their examination.

Signature _____

Emergency Contact Name _____

Phone _____

Relationship _____

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 _____
Race _____	Ethnicity _____	Language _____
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? Internet Search Website Friend _____

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

Reason for Visit: New Patient Consult Annual Routine Cataract Glaucoma

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 thimerosal

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

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

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

Family History: Please specify relationship to patient

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

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