Willow Street Eye Care, LLC

Patient Information Form

All information is strictly confidential

Name _____ Date of Birth_____
Last First Middle

Nickname _____ Gender _____

Address _____
Street City State Zip Code

Home Phone _____ Cell Phone _____

Email Address _____ Guardian Name (under 18) _____

Employer _____ Work Phone _____

Occupation _____ Family Doctor _____

Family Members Seen Here _____ Referral Source

[ ] Previous Patient: _____
[ ] Website
[ ] Another Doctor: _____
[ ] Other: _____

Medical Insurance

Required as "medical eye conditions" will be billed to your primary medical insurance

Insurance Type _____ Policy Number _____

Insured Name _____ SSN of Insured _____

Insured Date of Birth _____ Group/Policy Number _____

Refraction is not covered by Medicare and must be paid by the patient at the time of service

MEDICAL RECORDS RELEASE/PAYMENT AUTHORIZATION/LIFETIME SIGNATURE ON FILE

Vision Insurance

Routine vision exams will be billed to your vision insurance

Insurance Type _____ Policy Number _____

Insured Name _____ SSN of Insured _____

Insured Date of Birth _____ Group/Policy Number _____

I authorize payment of all Medicare, Medigap or other insurance benefits for services rendered by this office to be made payable either by me or on my behalf to *Willow Street Eye Care, LLC*.

I hereby authorize this office to release to the Health Care Financing Administration and its agents and/or to any Medigap or other insurer, any information necessary to determine the benefits payable for related services. I permit a copy of this authorization to be used in place of the original. I understand that I am responsible for all charges not covered by insurance benefits.

Patient Signature (Parent/Guardian of minor) _____ **Date** _____

Willow Street Eye Care, LLC

Reason for your visit today _____

Ocular History

Have <u>YOU</u> ever been diagnosed or treated for the following conditions?

Cataract	_____	Glaucoma	_____	Macular Degeneration	_____
Corneal Disease	_____	Retinal Disease	_____	Blindness	_____
Lazy Eye	_____	Eye Injury	_____	Other (specify)	_____

Please list all previous eye surgeries _____

Please list any <u>family members</u> who have been diagnosed or treated for the following conditions

Cataract	_____	Glaucoma	_____	Macular Degeneration	_____
Blindness	_____	Lazy Eye	_____	Other (specify)	_____

Are you currently experiencing any of the following (check all that apply)

Blurred Vision	_____	Flashes	_____	Sandy/Gritty Sensation	_____
Vision Loss	_____	Floaters	_____	Eye Pain or Soreness	_____
Halos/Glare	_____	Redness	_____	Light Sensitivity	_____
Loss of Side Vision	_____	Burning	_____	Swelling of Eye or Lid	_____
Double Vision	_____	Itching	_____	Excessive Watering	_____
Headaches	_____	Other (specify)	_____		

Medical History

Please list your current medications (including vitamins) and dosage

_____ _____

_____ _____

_____ _____

_____ _____

Medication Allergies _____

Previous Surgeries _____

Have YOU ever been diagnosed or treated for the following conditions?

High Blood Pressure	_____	Cancer (type)	_____	Neurological Disease	_____
High Cholesterol	_____	Migraine	_____	Asthma/Emphysema/COPD	_____
Heart Disease	_____	Thyroid Disease	_____	Sleep Apnea	_____
Diabetes	_____	Arthritis	_____	Autoimmune Disease	_____
Stroke	_____	Other (specify)	_____		

Are you currently pregnant or nursing? _____

Substance	Currently Use?	Previously used?	Type/Amount/Frequency	How Long? (Years)	If Stopped, When? (Year)
Tobacco	[ ] N [ ] Y	[ ] N [ ] Y			
Alcohol	[ ] N [ ] Y	[ ] N [ ] Y			
Recreational Drugs	[ ] N [ ] Y	[ ] N [ ] Y			