

Pt ID # _____

Patient Information (Provide legal name as it appears on your insurance)

Last name:		First:		Middle:	Birth date:	
Address:				<input type="checkbox"/> Employed <input type="checkbox"/> Student FT or PT <input type="checkbox"/> Retired <input type="checkbox"/> Self		Marital status (circle one) Single / Mar / Div / Sep / Wid
City	State	ZIP				
Home Phone: () ()		Mobile: () ()		Occupation:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Reason for today's visit:				Email Address:		
How did you hear about us?						
Are you a new patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		Whom may we thank for referring you?		Are you here for Routine Vision Exam? Yes / No		
				Are you here for a Medical Reason? Yes / No		
Do you have Vision Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other					Name of MEDICAL Insurance:	
Name of Vision Insurance: VSP BCBS EyeMed Avesis Medicare Aetna Cigna Other:						
Name of Insured Member:				Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		
Insured member's SS#		Insured's Date of birth: / /		Employer name:		
Insurance ID#		Group #		Driver Lic #		

PLEASE ANSWER THE FOLLOWING QUESTIONS

Do you currently wear contact lenses? Yes No if you answered no, would you like to be fitted for contacts? Yes No Contact Lens Fees apply – Ask front desk

What kind of contact lenses do you currently wear? _____ Name of Contacts _____

Contact lens exams are in addition to routine eye exams and require a contact fitting. **New fittings \$75, hard contact fittings \$120 and all others \$45.** _____ initial

Would you like your eyes dilated today? Yes No Dilation is included with the exam. We can take a retinal photo for \$30 to avoid dilating your eyes. Y / N

Do you currently wear glasses? Yes No if you answered yes, how old are they? _____ What type of lenses? _____

Hobbies: _____

Do you work on a computer? Yes No How many hours per day do you spend on the computer? _____

Do you have any allergies? Yes No _____

Medications you are currently taking: _____

- | | | |
|--|---|---|
| Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Family | Lazy Eye <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Family | Macular degeneration <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Family |
| High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Family | Eye Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Family | Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Family |
| Cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Family | LASIK <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Family | Head/Eye injury <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Family |
| Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Family | Retinal Detachment <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Family | Heart problems <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Family |
| Loss of vision <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Family | Double Vision <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Family | Thyroid problems <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Family |
| Dry Eye <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Family | OTHER: _____ | |

If you are here for a medical reason other than a routine vision exam, please provide the front desk with a copy of your medical card and a photo ID. All medical visits are billed to your medical insurance and all non covered fees are the responsibility of the patient. If the doctor discovers a medical condition during the routine eye exam, the medical condition will have to be treated before a routine eye exam can be performed.

HIPAA Acknowledgement Form

I have received the Notice of Privacy Practices for my records and I have been provided the opportunity to review it. The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any non covered balance. I also authorize Peoria Eye Care and/ or my insurance company to release any information required to process my claims.

Patient/Guardian signature

Print full name of patient

_____/_____/_____
Date