IN FOCUS EYE CENTER

PATIENT INFORMATION

Last Name _____

First Name _____

Preferred Name _____

Address _____

Unit #_____ City_____

State _____ Zip Code _____ Sex: M F

DOB _____ Age_____

SSN _____

We use an automated reminder/notification system. To ensure you receive these messages, we assume that your mobile number is the preferred contact.

Mobile Phone_____

Home/Other Phone _____

Email _____

Occupation _____

Employer_____

What is the major purpose of today's visit?

_____

_____

LIFESTYLE

Do you -

☐ have prescription eyewear?

☐ have back-up glasses that you can rely on?

☐ currently use sunglasses?

☐ have a commute where you are facing the sun?

☐ have interest in vision correction surgery?

☐ have family members who may need eye care?

INSURANCE INFORMATION

Major Medical_____

Vision Benefit _____

Who is the policy holder?

☐ Self ☐ Spouse/Partner ☐ Parent

Subscriber Name _____

Subscriber DOB _____

Subscriber ID/SSN _____

REFERRAL INFORMATION

How did you find out about us?

☐ Insurance List

☐ Advertisement

☐ Family Member _____

☐ Other Doctor _____

☐ Friend _____

☐ Website _____

FINANCIAL AND PRIVACY RESPONSIBILITIES

In Focus Eye Center is happy to directly bill insurance for our patients when possible; however, we do not guarantee insurance payment. Any remaining balance after insurance benefits are applied is the responsibility of the patient. While we do our due diligence to inform our patients of their balances, any amount that is not paid within 90 days is considered overdue and will be sent to a collections agency.

In the event of a credit patients will receive a prompt refund for all amounts $25 or more while all other will be credited to our patient's account, unless requested in writing.

Payments by check that are returned as Insufficient Funds will be charged $40 for processing.

All patients must read through the attached “Notice of Privacy Practices.” Any questions can be addressed to our staff.

“I understand and agree to the above Financial Responsibilities as well as the Notice of Privacy Practices for In Focus Eye Center.”

Signature _____

Date _____

If the patient is a minor, please sign above to indicate you give permission to treat the patient today and print your name here

_____

EYE HISTORY

Date of Last eye examination _____

Do you wear contact lenses? ☐ Yes ☐ No

☐ Soft ☐ Rigid/Hard

EYE CONDITIONS

Have you ever been diagnosed with or treated for:

- ☐ Cataract
- ☐ Macular degeneration
- ☐ Glaucoma
- ☐ Diabetes
- ☐ Diabetic retinopathy
- ☐ Dry eye
- ☐ Eye infection
- ☐ Flashes of light
- ☐ Floaters
- ☐ Iritis or Uveitis
- ☐ Retina defects
- ☐ Retina degeneration
- ☐ Retinal detachment
- ☐ Eye surgery
- ☐ Eye injury
- ☐ Keratoconus
- ☐ Turned/crossed eyes
- ☐ Corneal abrasion

Other _____

_____

EYE CONCERNS

Do you experience any of the following:

- ☐ Redness
- ☐ Burning
- ☐ Itching
- ☐ Tearing
- ☐ Discharge
- ☐ Dryness
- ☐ Grittiness

VISION CONCERNS

Have you noticed any of the following:

- ☐ Blurred vision
- ☐ Eye strain
- ☐ Eye pain
- ☐ Sensitivity to light
- ☐ Headaches
- ☐ Poor night vision
- ☐ Bothersome night glare
- ☐ Double vision
- ☐ Total loss of vision

Other _____

_____

_____

GENERAL HEALTH REVIEW

- ☐ Cancer
- ☐ Multiple sclerosis
- ☐ Stroke
- ☐ Migraine
- ☐ High blood pressure
- ☐ Asthma
- ☐ Arthritis
- ☐ Shingles
- ☐ Eczema
- ☐ Type 1 diabetes
- ☐ Type 2 diabetes
- ☐ Thyroid dysfunction
- ☐ Environmental allergies
- ☐ Lupus
- ☐ Sjogren's Syndrome

Other _____

_____

Are you pregnant or nursing now? ☐ Yes ☐ No

CURRENT MEDICATIONS

(Rx and non-Rx, including drops, vitamins and birth control):

_____

_____

ALLERGIES TO MEDICATIONS

_____

_____

FAMILY HISTORY

Are any of the following conditions present in any members of your blood relatives?

- ☐ Diabetes
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Cancer
- ☐ Macular Degeneration
- ☐ Glaucoma
- ☐ Cornea or Retinal issues

Other _____

_____

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