

Thank you for choosing our office for your eye care. To assist our staff in providing you with the best care, please provide the following information.

Patient Information

Title: Mr. Mrs. Ms. Miss Please circle one

Name: _____

Birthdate: _____

SS#: _____

Address/Apt#: _____

City/State/Zip: _____

Home Phone: _____

Cell Phone: _____

Texting ok? yes/no Please circle one

Email: _____

Preferred Communication? Phone Email Cell Text

Single Married Divorced Widowed
Please circle one

If Minor, Parent or Guardian's name

Employment Information

Patient's Employment Status: Please circle one

Full-time employed Student Retired

Part-time employed Not employed Self-employed

Occupation: _____

Employer: _____

Address: _____

City/State/Zip: _____

Phone: _____

Insurance Information

Medical Insurance: _____

Vision Insurance: _____

Policy Holder's Info (if not patient)

Name: _____

Home Address: _____

City/State/Zip: _____

Phone: _____

Employer: _____

Birthdate: _____

Relation to Patient: _____

How did you hear about our office?

Please circle one

I'm a Prior Patient Phone Book Newspaper
Insurance Internet Other Referral (see below)

Patient referral: _____

Doctor referral: _____

Emergency Information

Emergency Contact: _____

Relation to Patient: _____

Phone: _____

Primary Care Physician: _____

Address: _____

City/State/Zip: _____

Phone: _____

Authorization

I certify that I have read, understood, and provided the above information to the best of my knowledge. I understand that providing incorrect information to this office or the doctor may be dangerous to my health. I authorize the doctor and staff to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such eye care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the doctor or Swanson Eyecare, PC any insurance benefits intended for the payment of eye care services to me or my dependents.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered to me or my dependents. I understand that returned checks will be charged a \$30.00 fee and that any account over 30 days past due will be subject to a \$15.00 late fee as well as collection proceedings.

Missed appointments or appointments cancelled/re-scheduled with less than 24 hours notice will be charged a \$25 cancellation fee.

I acknowledge that I have received a copy of Notice of Privacy Practices for Swanson Eyecare, PC.

X _____ Date: _____

SIGNATURE OF PATIENT (if patient is a minor, signature of guardian)

*To ensure compliance with new Federal health care laws, we ask that you update your health information below.
We thank you for your patience as we transition to computerized records!*

NAME: _____ **DATE:** _____

Ocular History

Have you ever had any of the following eye conditions?

	Yes	No	<u>Additional Information</u>
Cataract/Cataract surgery	Yes	No	_____
Glaucoma	Yes	No	_____
Macular Degeneration	Yes	No	_____
Lazy Eye/Strabismus	Yes	No	_____
Eye Surgery	Yes	No	_____
LASIK/refractive surgery	Yes	No	_____
Eye Injury	Yes	No	_____

Do you wear contact lenses? Yes No
 Type? Soft Disposable Hard/RGP Other
 I wear my contacts _____ hours per day
 Do you sleep in your contacts? No Yes
 Which disinfecting system do you use? _____

How many hours do you use a computer each day? _____

Medical History

Allergies	Yes	No
Arthritis	Yes	No
Asthma/Emphysema	Yes	No
Other Lung Disease	Yes	No
Blood/Bleeding Disorder	Yes	No
Cancer (Type _____)	Yes	No
Diabetes (Type _____)	Yes	No

What was your most recent blood sugar reading? _____

What was your most recent HbA1c reading? _____

Headaches	Yes	No
Heart Attack/Heart Failure	Yes	No
High Blood Pressure	Yes	No
High Cholesterol	Yes	No
Kidney/Urinary Disease	Yes	No
Migraines	Yes	No
Peripheral Vascular Disease	Yes	No
Rosacea	Yes	No
Sarcoidosis	Yes	No
Sjogren's Syndrome	Yes	No
Skin Disease or Disorder	Yes	No
Sleep Apnea	Yes	No
Stomach/Intestinal Disorder	Yes	No
Stroke/Neurological Disease	Yes	No
Thyroid Disease	Yes	No

Medications

Please list all prescription and non-prescription medications you are currently taking

Ocular Medications

Please list all medication allergies:

Surgical History

Type: _____ Date: _____
 Type: _____ Date: _____
 Type: _____ Date: _____
 Type: _____ Date: _____

Systemic Family History

Do any of your blood relatives have any of these conditions?

Diabetes	Yes	No
Heart Disease	Yes	No
Stroke	Yes	No
Cancer	Yes	No
Other: _____		

Ocular Family History

Glaucoma	Yes	No
Cataracts	Yes	No
Macular Degeneration	Yes	No
Lazy Eye/Strabismus	Yes	No
Other _____		

