PATIENT INFORMATION FORM

Today's Date:_____/_____/_____

Name: Last_____First_____MI_____ M □ F □

Address:_____City:_____State:_____Zip_____

Home Phone: ( )_____Work Phone: ( )_____ Date of Birth_____ Age:_____

Occupation:_____ Employer/School:_____

Marital Status: Single □ Married □ Divorced □ Widowed □
Are you pregnant and/or nursing? Yes No
Are you allergic to any medications: Yes No If yes, list the medications:_____
List any medications you currently take (Prescriptions and over the counter):_____
_____
List any eye injuries or surgeries you have had: _____
History of or current exposure to chemicals, fumes, or potential eye hazards:_____
Do you smoke? Yes No If yes, how much? _____ packs/day Started _____yrs. ago
Do you drink alcohol? Yes No If yes, how often? _____

Primary Reason for today's visit:_____ Referred by:_____
Date of Last Eye Exam: _____/_____/_____Last Eye Doctor:_____

EYEWEAR HISTORY

Do you wear glasses? Yes No If yes, how old is your current pair of glasses? _____
Do you wear contacts? Yes No If yes, how old is your current pair of lenses? _____
Do you sleep in contact lenses? Yes No If yes, how often? _____
Are your current contacts comfortable? Yes No
Contact Brand: _____ Replacement: _____ Solution Brand: _____

PRIVACY PRACTICES ACKNOWLEDGEMENT

By initialing below, I have been offered a copy of my HIPPA rights. I understand that Inlet Optometric Eyecare, Inc. will provide any protected health information that I request upon completion of a records release form.

_____
Initials of patient or legal guardian

INSURANCE AUTHORIZATION

By initialing below, I am authorizing assignment of my insurance rights and benefits directly to Inlet Optometric Eyecare, Inc. for services rendered. I fully understand I am solely responsible for any balance not paid by the insurance company.

_____
Initials of patient or legal guardian

Please turn this form over and complete side 2

MEDICAL HISTORY

Do **YOU** currently have any problems in the following areas?

EYES	**Y**	**N**	**Explanation**		**Y**	**N**	**Explanation**
Loss of vision				**RESPIRATORY**			
Blurred vision				Asthma			
Flashes of light				Emphysema, etc.			
Loss of side vision				**GASTROINTESTINAL**			
Double vision				Stomach ulcers			
Dryness				Intestinal disease, etc.			
Mucous discharge				**MUSCLE, BONES, JOINTS**			
Redness				Arthritis, etc.			
Sandy or gritty feeling				**SKIN**			
Itching				Skin Cancer			
Burning				**NEUROLOGICAL**			
Foreign body sensation				Headaches			
Excess tearing/watering				Migraines			
Glare/light sensitivity				Brain Injury/Stroke			
Eye pain or soreness				**PSYCHIATRIC**			
Floaters				Anxiety, depression			
Crossed eyes, lazy eye				Insomnia, etc.			
Drooping eyelid				**ENDOCRINE**			
GENERAL/CONSTITUTIONAL				Diabetes			
Fever				Hypothyroid, etc.			
Other				**BLOOD/LYMPH**			
Weight Loss				Anemia, etc.			
EAR, NOSE and THROAT				High Cholesterol			
Sinus, ear infection				**ALLERGIC/IMMUNOLOGIC**			
Chronic cough, Dry mouth				Hay fever, lupus			
CARDIOVASCULAR				Sjogrens, etc.			
Heart				**GENITAL, KIDNEY, BLADDER**			
High Blood Pressure							

FAMILY HISTORY

Please note any family history (self, parents, grandparents, siblings, and/or children, living or deceased) for the following medical conditions:

DISEASE	**Y**	**N**	**RELATIONSHIP TO PATIENT**	**DISEASE**	**Y**	**N**	**RELATIONSHIP TO PATIENT**
Blindness				Diabetes			
Cataract				Heart Disease			
Crossed Eyes				High Blood Pressure			
Glaucoma				Kidney Disease			
Macular Degeneration				Lupus			
Retinal Detachment				Stroke			
Arthritis				Thyroid Disease			
Cancer				Other			

OFFICE POLICY

All fees are due at the time of the initial exam unless assignment has been approved from your vision/medical insurance carrier. Your insurance card must be present at the time of service in order for us to get prior authorization. Professional fees will not be refunded under any circumstances. Inlet Optometric Eyecare, Inc. will provide the appropriate documentation to the patient so that the claim can be filed individually if we are not a provider for your insurance.