EYECARE
REGISTRATION AND HISTORY

MooreEyes Family Vision Center llc

PATIENT INFORMATION

Date_____ SS#_____

Patient Name_____
Last First Middle Init.

Address_____

City_____ State_____ Zip_____

E-mail_____

Sex ❑ M ❑ F Age_____ Birthdate_____

❑ Married ❑ Widowed ❑ Single ❑ Minor

❑ Separated ❑ Divorced ❑ Partnered for_____ years

Occupation_____

Patient Employer/School_____

Employer/School Address_____

_____Phone_____

Spouse's Name_____

Birthdate_____ SS#_____

Spouse's Employer_____

Whom may we thank for referring you?_____

INSURANCE

Who is responsible for this account?_____

Relationship to Patient _____

Insurance Co. _____

Group #_____

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscribers Name_____Birthdate_____

SS#_____Relationship to Patient_____

Insurance Co. _____Group #_____

ASSIGNMENT AND RELEASE

I certify that I and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

PHONE NUMBERS

Home (_____)_____ Cell (_____)_____ Work Phone(_____)_____ Ext _____

Best time and place to reach you_____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name_____ Relationship_____

Home (_____)_____ Cell (_____)_____ Work Phone(_____)_____ Ext _____

EYE HEALTH HISTORY

Date of last eye exam_____

Name of last eye doctor_____

Do you wear glasses? ❑ Yes ❑ No

❑ All the time ❑ Occasionally

❑ Reading ❑ Driving ❑ TV

Do you wear contact lenses? ❑ Yes ❑ No

Type_____ Hours/Day _____

What type of contact lens solution do you use?

_____

Describe any problems you have with your contact lenses _____

_____

Place a mark on "Yes" or "No" to indicate if you have had or currently have any of the following:

Bloodshot Eyes	❑ Yes	❑ No	Floaters or Spots	❑ Yes	❑ No
Blurred Vision - Distance	❑ Yes	❑ No	Glaucoma	❑ Yes	❑ No
Blurred Vision - Near	❑ Yes	❑ No	Headaches	❑ Yes	❑ No
Burning Eyes	❑ Yes	❑ No	Itching Eyes	❑ Yes	❑ No
Cataracts	❑ Yes	❑ No	Light Sensitivity	❑ Yes	❑ No
Poor Color Vision	❑ Yes	❑ No	Loss of Vision	❑ Yes	❑ No
Crossed Eyes	❑ Yes	❑ No	Macular Degeneration	❑ Yes	❑ No
Discharge from Eyes	❑ Yes	❑ No	Migraine Headaches	❑ Yes	❑ No
Dizzy Spells	❑ Yes	❑ No	Poor Night Vision	❑ Yes	❑ No
Double Vision	❑ Yes	❑ No	Red Eyes	❑ Yes	❑ No
Dry Eyes	❑ Yes	❑ No	Seeing Halos	❑ Yes	❑ No
Eye Infection	❑ Yes	❑ No	Seeing Flashes	❑ Yes	❑ No
Eye Injury	❑ Yes	❑ No	Temporary Loss of Vision	❑ Yes	❑ No
Eye Strain/Soreness	❑ Yes	❑ No	Excess Tearing/Watering	❑ Yes	❑ No
Fainting Spells, Blackouts	❑ Yes	❑ No			

HEALTH HISTORY

Physician's Name _____ Date of last visit_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following. Also place a mark to indicate if a blood relative has had any of the following problems.

	Yourself	Family Members		Yourself	Family Members
Allergies / Hay Fever	❑ Yes ❑ No	❑ Yes ❑ No	High Blood Pressure	❑ Yes ❑ No	❑ Yes ❑ No
Arthritis	❑ Yes ❑ No	❑ Yes ❑ No	Kidney Disease	❑ Yes ❑ No	❑ Yes ❑ No
Artificial Heart Valve	❑ Yes ❑ No	❑ Yes ❑ No	Lazy Eye	❑ Yes ❑ No	❑ Yes ❑ No
Artificial Joints	❑ Yes ❑ No	❑ Yes ❑ No	Lupus	❑ Yes ❑ No	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	❑ Yes ❑ No	Migraine Headaches	❑ Yes ❑ No	❑ Yes ❑ No
Bleeding	❑ Yes ❑ No	❑ Yes ❑ No	Pacemaker	❑ Yes ❑ No	❑ Yes ❑ No
Blindness	❑ Yes ❑ No	❑ Yes ❑ No	Poor Color Vision	❑ Yes ❑ No	❑ Yes ❑ No
Cancer	❑ Yes ❑ No	❑ Yes ❑ No	Retinal Disease	❑ Yes ❑ No	❑ Yes ❑ No
Cataracts	❑ Yes ❑ No	❑ Yes ❑ No	Rheumatic Fever	❑ Yes ❑ No	❑ Yes ❑ No
Chemical Dependency	❑ Yes ❑ No	❑ Yes ❑ No	Shingles	❑ Yes ❑ No	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	❑ Yes ❑ No	Skin Conditions	❑ Yes ❑ No	❑ Yes ❑ No
Drug Sensitivity	❑ Yes ❑ No	❑ Yes ❑ No	Stroke	❑ Yes ❑ No	❑ Yes ❑ No
Emphysema	❑ Yes ❑ No	❑ Yes ❑ No	Thyroid Conditions	❑ Yes ❑ No	❑ Yes ❑ No
Epilepsy / Seizures	❑ Yes ❑ No	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No	❑ Yes ❑ No
Eye Surgery	❑ Yes ❑ No	❑ Yes ❑ No	Turned Eye	❑ Yes ❑ No	❑ Yes ❑ No
Glaucoma	❑ Yes ❑ No	❑ Yes ❑ No	Are you pregnant?_____	Number of children_____	
Heart Condition	❑ Yes ❑ No	❑ Yes ❑ No	Tobacco use_____	Alcohol use_____	

Have you ever been exposed to or infected with: ❑ Gonorrhea ❑ Hepatitis(Type___) ❑ HIV/AIDS ❑ Syphillis ❑ No, I have not

MEDICATIONS

List any medications you are currently taking, including eye drops:

_____

_____

Pharmacy Name_____

Phone(_____)_____

ALLERGIES

List your allergies to medications or other substances:

_____

_____

_____

_____

HIPAA PRIVACY STATEMENT

I have been shown and offered a copy of the HIPAA policies for this office, and have read and understand my rights therein. By signing I authorize and consent for release of information.

Signature:_____ Date:_____

DO NOT WRITE BELOW THIS LINE *(Doctors Comments)*

_____

_____

_____

_____

I have reviewed this history with the patient:_____

Doctor's Signature *Date*