Patient Information

Date: _____

Patient: _____

Street Address: _____

City: _____

State: _____ Zip: _____

Sex: ☐M ☐F Age: _____ DOB: _____

☐ Single ☐ Married ☐ Widowed

☐ Separated ☐ Divorced

Patient SS#: _____

Occupation: _____

Employer: _____

Employer Address: _____

_____

Spouse's Name: _____

DOB: _____ SS#: _____

Occupation: _____

Spouse's Employer: _____

How did you hear about us? (If from another patient, who may we thank for referring you?)

_____

_____

Insurance

Who is responsible for this account?

_____

Relationship to Patient: _____

Insurance Co.: _____

Member ID #: _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name: _____

DOB: _____ SS#: _____

Relationship to Patient: _____

Insurance Co.: _____

Member ID #: _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and have assigned directly to Campus Eye Group 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature:

_____

Relationship: _____ Date: _____

Contact Information

Home: _____ Work: _____ Ext. _____ Cell Phone: _____

Spouse's Work: _____ Best time and place to reach you: _____

Email Address: _____ (for CEG use only)

In Case of Emergency, Contact

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Campus Eye Group for any services furnished me by that doctor. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services.

_____ _____

Signature Date

Medications

List any medications **and** eye drops you are currently taking:

_____

_____

_____

_____

_____

Pharmacy Name:_____

Phone: _____

Allergies

List your allergies to medications or other substances:

_____

_____

_____

_____

_____

_____

_____

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 Member	
AIDS/HIV	□ Yes	□ No	□ Yes	□ No
Arthritis	□ Yes	□ No	□ Yes	□ No
Asthma	□ Yes	□ No	□ Yes	□ No
Bleeding	□ Yes	□ No	□ Yes	□ No
Cancer	□ Yes	□ No	□ Yes	□ No
Chemical Dependency	□ Yes	□ No	□ Yes	□ No
Diabetes	□ Yes	□ No	□ Yes	□ No
Drug Sensitivity	□ Yes	□ No	□ Yes	□ No
Emphysema	□ Yes	□ No	□ Yes	□ No
Epilepsy	□ Yes	□ No	□ Yes	□ No
Glaucoma	□ Yes	□ No	□ Yes	□ No
Hay Fever	□ Yes	□ No	□ Yes	□ No
Headaches	□ Yes	□ No	□ Yes	□ No
Heart Problems	□ Yes	□ No	□ Yes	□ No
Hepatitis	□ Yes	□ No	□ Yes	□ No

	Yourself		Family Member	
High Blood Pressure	□ Yes	□ No	□ Yes	□ No
Kidney Disease	□ Yes	□ No	□ Yes	□ No
Lupus	□ Yes	□ No	□ Yes	□ No
Pacemaker	□ Yes	□ No	□ Yes	□ No
Rheumatic Fever	□ Yes	□ No	□ Yes	□ No
Shingles	□ Yes	□ No	□ Yes	□ No
Skin Conditions	□ Yes	□ No	□ Yes	□ No
Stroke	□ Yes	□ No	□ Yes	□ No
Thyroid Condition	□ Yes	□ No	□ Yes	□ No
Ulcers	□ Yes	□ No	□ Yes	□ No
Tobacco Use	□None	□Medium	□Heavy	
Alcohol Use	□None	□Medium	□Heavy	

List all previous surgeries:

_____

_____

Eye Health History

Date of last eye exam: _____

Name of doctor: _____

Do you wear glasses: ☐ Yes ☐ No

☐ All the time ☐ Occasionally ☐ Reading

☐ Driving ☐ During TV

Do you wear contacts: ☐ Yes ☐ No

Type: _____ Hours/Day: _____

Describe any problems you have with your contacts:

_____

_____

Place a mark on "Yes" or "No" to indicate if you have had 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 Sensitive	□ Yes	□ No
Color Vision Poor	□ Yes	□ No	Loss of Vision	□ Yes	□ No
Crossed Eyes	□ Yes	□ No	Migraine Headaches	□ Yes	□ No
Discharge from Eyes	□ Yes	□ No	Night Vision Poor	□ Yes	□ No
Dizzy Spells	□ Yes	□ No	Red Eyes	□ Yes	□ No
Double Vision	□ Yes	□ No	Seeing Halos	□ Yes	□ No
Dry Eyes	□ Yes	□ No	Seeing Flashes	□ Yes	□ No
Eye Infection	□ Yes	□ No	Temporary Loss of Vision	□ Yes	□ No
Eye Injury	□ Yes	□ No	Twitching Eyelid	□ Yes	□ No
Eye Strain	□ Yes	□ No	Vision Poor	□ Yes	□ No
Fainting Spells, Blackouts	□ Yes	□ No	Watering Eyes	□ Yes	□ No

Would you be interested in receiving information about any of the following:

Laser vision correction (LASIK)?	□ Yes	□ No
New contact lens technology?	□ Yes	□ No
Transition lenses?	□ Yes	□ No
Anti-reflective coating?	□ Yes	□ No