# Advanced Eyecare Patient Information Form

*Welcome to Advanced Eyecare! For faster service, please complete this form prior to your appointment. Please print or type in this form.*

## *Patient Information*

First Name: _____ MI: ____ Last Name: _____ Today's Date: _____

Preferred Name (i.e. Bob vs. Robert): _____ Date of Birth (MM/DD/YY): _____

Parent or Guardian (If Applicable): _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ E-mail: _____

How did you learn about our office? _____

Primary Care Physician: _____

Occupation & Employer: _____

School Attending & Grade Level (If Applicable): _____

**How do you prefer we contact you?** ☐ Home Phone ☐ E-mail ☐ Mobile Phone ☐ Text Message ☐ Work Phone ☐ U.S. Mail

In case of emergency, contact: _____

Relationship: _____ Emergency Phone: _____

**Gender:**
☐ Male ☐ Female

**Race/Ethnicity:**
☐ White (Not Hispanic)
☐ Hispanic/Latino
☐ African American/Black
☐ Asian
☐ American Indian/Eskimo
Other (Specify): _____
☐ *Prefer not to answer*

**Marital Status:**
☐ Single ☐ Married
☐ Other: _____

**Current Corrective Lenses:**
☐ Glasses ☐ Contacts
☐ None

## *Primary Insurance*

Medical Insurance Company: _____ Vision Insurance Company: _____

Subscriber Name: _____

**Gender:**
☐ Male ☐ Female

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

SSN _____ Subscriber Date of Birth (MM/DD/YY): _____

Employer: _____

## *Secondary Insurance*

If you have a secondary health insurance provider, please list the insurance company and policy number here:

☐ *By checking this box, I authorize the release of any medical information necessary to provide the most beneficial and complete visual examination. I understand that I am financially responsible for all charges, regardless of insurance benefits. Payment is due at the time services are rendered.*

☐ *By checking this box, I acknowledge that I have received a copy of Advanced Eyecare's Notice of Privacy Practices (HIPAA Compliance).*

***Patient or Parent/Guardian Signature:*** _____ Today's Date: _____

***Please turn over form and enter health history information.*** ------>

## *Health History*

Please provide us with your health information by checking all of the boxes that currently apply.

***Allergic/Immunologic***
- ☐ Drug allergy
- ☐ Environmental allergy
- ☐ Rheumatoid arthritis
- ☐ **None**

***Eyes***
- ☐ Glaucoma
- ☐ Cataract
- ☐ Macular Degeneration
- ☐ Surgery
- ☐ Blurred vision
- ☐ **None**

***Musculoskeletal***
- ☐ Fibromyalgia
- ☐ Muscular dystrophy
- ☐ Osteoarthritis
- ☐ Ankylosing spondylitis
- ☐ **None**

***Cardiovascular***
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Stroke
- ☐ Vascular disease
- ☐ **None**

***Gastrointestinal***
- ☐ Crohn's
- ☐ Colitis
- ☐ Ulcer
- ☐ Digestive
- ☐ **None**

***Neurological***
- ☐ Multiple sclerosis
- ☐ Epilepsy
- ☐ Alzheimers
- ☐ Parkinsons
- ☐ Cerebrovascular
- ☐ **None**

***Constitutional***
- ☐ Developmental disability
- ☐ Weight loss
- ☐ Fever
- ☐ Fatigue
- ☐ Trauma
- ☐ **None**

***Genitourinary***
- ☐ STD, Herpes, Chlamydia
- ☐ **None**

***Psychiatric***
- ☐ Depression
- ☐ Panic disorder
- ☐ Schizophrenia
- ☐ **None**

***Ear, Nose, Mouth & Throat***
- ☐ Respiratory Tract Infection
- ☐ Ear ache
- ☐ Runny nose
- ☐ Sore throat
- ☐ **None**

***Blood/Lymphatic***
- ☐ Anemia
- ☐ Large volume blood loss
- ☐ Leukemia
- ☐ **None**

***Respiratory***
- ☐ Current smoker
- ☐ Previous smoker
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ **None**

***Endocrine***
- ☐ Type 1 diabetes
- ☐ Type 2 diabetes
- ☐ Thyroid disorder
- ☐ Hormonal disorder
- ☐ **None**

***Skin***
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ **None**

Please list any other health issues/conditions that are not listed above.

## *Patient Allergies & Medications*

Allergies (list all allergies, including allergies to environments and/or medications):

Current medications (list both prescription and over-the-counter medications):
***If no medications taken, please write, "none" in box below.***

## *Family Health History*

Please check if there is any family history of any of the following:
- ☐ Blindness
- ☐ Cataracts
- ☐ Lazy Eye
- ☐ Diabetes
- ☐ Stroke
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ High blood pressure
- ☐ Heart disease

## *Do you participate in any of the following activities?*
- ☐ Water skiing
- ☐ Bicycling
- ☐ Scuba diving
- ☐ Softball
- ☐ Tennis
- ☐ Golfing
- ☐ Snow skiing
- ☐ Running
- ☐ Fishing
- ☐ Swimming
- ☐ Computer
- ☐ Piano/Organ
- ☐ Woodwork
- ☐ Shooting
- ☐ Racquetball

Hobbies: _____ _____ _____ _____ _____ _____

## *Do any of the following options appeal to you:*

☐ Thinner lenses ☐ Lightweight lenses ☐ Lenses that change in the sun ☐ No-line bifocals or trifocals

Do headlights bother you at night?____ Do you spend a fair amount of time in the sun?_____ Are you interested in learning more about lasik?_____