

Mountain Eye Care, PC

Last Name _____ First Name _____ MI _____
Address _____ City _____ State _____ Zip _____
Telephone (H) _____ (W) _____ ext. _____
Cell _____ Email _____
Date of Birth _____ Age _____ SSN _____ - _____ - _____
Occupation _____ Employer _____
Sex: Male Female Status: Single Married Separated Divorced Widowed
Date of Last Eye Exam _____ Dilated? _____ Today's Date _____
Whom may we thank for referring you? (Friend, sign, yellow pages, etc...) _____

Billing & Insurance Info:

Vision: _____ Policy Holder's Name _____
Policy Holders: DOB _____ SSN _____

Medical Insurance:

Primary: _____ Policy Holder's Name _____
Policy Holders: DOB _____ SSN _____

Secondary: _____ Policy Holder's Name _____
Policy Holders: DOB _____ SSN _____

Assignment and Release:

I certify that I and/or my dependents have insurance coverage with the insurance(s) listed above and assign directly to Mountain Eye Care, PC 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.

X
Signature of Patient/Guardian _____ **Print Name** _____ **Relationship to Patient** _____ **Date** _____

WHAT IS YOUR REASON FOR TODAY'S EYE EXAM? Please mark all that apply

<input type="checkbox"/> blur at a distance	<input type="checkbox"/> glaucoma	<input type="checkbox"/> tears/discharge	<input type="checkbox"/> contact lenses
<input type="checkbox"/> blur at near	<input type="checkbox"/> lazy eye	<input type="checkbox"/> eye pain/discomfort	<input type="checkbox"/> interested in LASIK
<input type="checkbox"/> double vision	<input type="checkbox"/> red eyes	<input type="checkbox"/> itching	<input type="checkbox"/> annual exam
<input type="checkbox"/> computer strain	<input type="checkbox"/> flashes	<input type="checkbox"/> dry eyes	<input type="checkbox"/> diabetic
<input type="checkbox"/> headache	<input type="checkbox"/> spots	<input type="checkbox"/> broken glasses	<input type="checkbox"/> other:explain _____

Which activities/hobbies do you enjoy doing? (This question is necessary to better meet your visual care needs.)

PLEASE TURN OVER AND FINISH FORM ON BACK

Patient Medical History

Primary Care Physician _____ Date of Last Physical Exam _____

Have you ever been diagnosed or treated for the following?

- Amblyopia/Lazy Eye Eye Injury Corneal Abrasion Iritis/Uveitis Retinal Detachment
- Cataracts Glaucoma Dry Eye Macular Degeneration

Have you ever had any eye operations? Y / N Type _____ Date _____

Have you ever had an eye injury? Y / N Type _____ Date _____

Do you wear glasses? Y / N How old are your current glasses? _____

Do you wear contact lenses? Y / N Type ___hard ___soft/disposable ___other Brand? _____

Review of Systems

Allergic/Immunologic None _____ **Endocrine** None _____ **Integumentary** None _____ **Psychiatric** None _____

- | | | | |
|--|--|------------------------------------|---|
| <input type="checkbox"/> Environmental | <input type="checkbox"/> Type I Diabetes | <input type="checkbox"/> Eczema | <input type="checkbox"/> Depression |
| <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Type II Diabetes | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Panic Disorder |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Thyroid Dysfunction | <input type="checkbox"/> Rosacea | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Other | <input type="checkbox"/> Other | <input type="checkbox"/> Other | <input type="checkbox"/> Other |

Cardiovascular None _____ **GI** None _____ **Musculoskeletal** None _____ **Respiratory** None _____

- | | | | |
|---|--|---|-------------------------------------|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Ankylosing Spondylitis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Colitis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Elevated Cholesterol | <input type="checkbox"/> Other | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Other |
| <input type="checkbox"/> Other | | <input type="checkbox"/> Other | |

Constitutional None _____ **Hematologic** None _____ **Neurological** None _____

- | | |
|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Other |
| <input type="checkbox"/> Trauma | |
| <input type="checkbox"/> Other | |

Do you take medications? Y / N If yes, list: _____

Do you have any allergies (environmental or to medication)? Y / N If yes, explain _____ X

Are you now pregnant? Y / N Are you nursing? Y / N

Social History:

Do you use any cigarettes/tobacco? Y / N Frequency _____

Alcohol? Y / N Frequency _____

Other substance(s)? _____ Y / N Frequency _____

Family History:

High blood pressure Y / N Relation _____	Macular degeneration Y / N Relation _____
Diabetes Y / N Relation _____	Retinal detachment Y / N Relation _____
Glaucoma Y / N Relation _____	Cataracts Y / N Relation _____
Blindness Y / N Relation _____	Crossed eye/lazy eye Y / N Relation _____
Other eye or health condition(s) Y / N What kinds? _____	Relation _____