History Review Date

Dr. Robert Grill – Dr. Steven Snapp – Dr. James Davis – Dr. Kyle Williams – Dr. Katherine Grill Nate

How did you hear about us? Yellow Pages ❒ Radio ❒ Newspaper ❒ TV ❒ Internet ❒ Insurance Company ❒

Referred by Doctor ❒ Please list their name:______________________________

Friend/Family ❒ Please list their name:______________________________

Patient:

Name ______________________ Date of Birth ____________ S.S.# ________-_______-_________

By what name would you like to be called?__________________ Age _________Gender: Male ❒ Female ❒

Mailing Address ____________________ Home Phone______________ Cell Phone ______________

City ________________ State________ Zip____________ Email______________________

How may we contact you? Electronically: Text ❒ Email ❒ By Phone: Home ❒ Cell ❒ Work ❒

Employer________________ Occupation________________ Work Phone ________________

Emergency Contact:__________________ Phone______________ Relationship to Patient____________

Medical Insurance ______________________________ Policy # ____________________

Vision Insurance ______________________________ Policy # ____________________

Do you have: Flex Plan ❒ Cafeteria Plan ❒ Medical Savings Plan ❒

Spouse or Parent: (Responsible Party)

Name ______________________________ Relationship ________________

Mailing Address ______________________________ Phone____________________

City __________________ State ________ Zip ______________S.S.# __________-________-__________

Birth Date ______________ Employer ______________________ Work Phone____________________

Is this individual financially responsible for your account? Yes ❒ No ❒

****

Primary Medical Dr:________________ Last Medical Exam: ____/_____/____ If female:pregnant /or nursing? No ❒ Yes ❒

When was your last Eye Exam _____/_____/______ Where was your last eye exam? Dr/Office______________________

Do you have any allergies to medications? No ❒ Yes ❒ If yes, explain: ____________________________

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

____

____

<u>Review of Systems:</u> (Patient)

Do you currently, or have you ever had any problems in the following areas:

EYES	NO	YES	?		NO	YES	?		NO	YES	?
Glaucoma	❒	❒	❒	Crossed/Lazy Eye	❒	❒	❒	Eye Pain/Ache	❒	❒	❒
Cataract	❒	❒	❒	Blind Eye	❒	❒	❒	Dryness	❒	❒	❒
Eye Surgery/Laser	❒	❒	❒	Loss of Vision	❒	❒	❒	Itching/Burning	❒	❒	❒
Eye Injury	❒	❒	❒	Double Vision	❒	❒	❒	Excess Redness	❒	❒	❒
Macular Degeneration	❒	❒	❒	Flashing Lights	❒	❒	❒	Excess Tearing	❒	❒	❒
Retinal Detachment	❒	❒	❒	Spots/Floaters	❒	❒	❒	Excess Lt. Sensitivity	❒	❒	❒

Please Continue on Back Side

Review of Systems Continued: (Patient)

Do you currently, or have you ever had any problems in the following areas:

NEUROLOGIC	NO	YES	?	BLOOD/LYMPHATIC	NO	YES	?	GASTROINTESTINAL	NO	YES	?
Headaches	❐	❐	❐	Anemia	❐	❐	❐	Diarrhea	❐	❐	❐
Migraines	❐	❐	❐	Bleeding/clotting Prob	❐	❐	❐	Constipation	❐	❐	❐
Seizures	❐	❐	❐	**Allergic/Immunologic**				**GENITOURINARY**			
CARDIO/VASCULAR				Allergies/Hayfever	❐	❐	❐	Kidney/Bladder Probs	❐	❐	❐
High Blood Pressure	❐	❐	❐	Chronic Cough	❐	❐	❐	Genital Problems	❐	❐	❐
Heart/Vascular Disease	❐	❐	❐	Rheumatoid Arthritis	❐	❐	❐	**CONSTITUTIONAL**			
Stroke	❐	❐	❐	Lupus	❐	❐	❐	Fever	❐	❐	❐
Fainting	❐	❐	❐	Sjrogren's	❐	❐	❐	Weight Loss/Gain	❐	❐	❐
RESPIRATORY				**PSYCHIATRIC**				Cancer	❐	❐	❐
Asthma	❐	❐	❐	Anxiety/Depression	❐	❐	❐	**INTEGUMENTARY & ENDOCRINE**			
Emphysema	❐	❐	❐	Emotional/Psychologic	❐	❐	❐	Skin Prob/Disorder	❐	❐	❐
Chronic Bronchitis	❐	❐	❐	**BONES/MUSCLES**				Thyroid Problem/Surg	❐	❐	❐
Sinus Congestion	❐	❐	❐	Arthritis	❐	❐	❐	Diabetes	❐	❐	❐
Dry Throat/Mouth	❐	❐	❐	Joint/Muscle Pain	❐	❐	❐				
Sleep Apnea	❐	❐	❐	Chronic Back Pain	❐	❐	❐				

If you answered YES to any of the above or have a condition not listed please explain:

____

____

Family History:

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

CONDITION	NO	YES	?		NO	YES	?		NO	YES	?
Blindness	❐	❐	❐	Macular Degeneration	❐	❐	❐	Heart Disease	❐	❐	❐
Cataract	❐	❐	❐	Retinal Detachment	❐	❐	❐	Arthritis	❐	❐	❐
Crossed Eyes	❐	❐	❐	Diabetes	❐	❐	❐	Cancer	❐	❐	❐
Glaucoma	❐	❐	❐	High Blood Pressure	❐	❐	❐	Thyroid Disease	❐	❐	❐

If yes, please list the relationship: ____

Social History:

Do You Smoke? No ❐ Yes ❐ If yes, type / amount / how long:_____________________________

Are you a former smoker? No ❐ Yes ❐

Corrective Lens History:

Do you wear glasses? No ❐ Yes ❐ If yes: How old are they?______________

Are you having any problems with them?____________________________________

Are there ever times you would prefer to go without your glasses? No ❐ Yes ❐

Do you wear contact lenses? No ❐ Yes ❐

If yes: What type? Rigid ❐ Soft ❐ Disposable ❐ Extended Wear ❐ Other________________________________

How old are your present contacts? ______________ How is your comfort on a scale of 1-10?____________________

How is your vision?____

How many hours per day do you spend on a computer or electronic device?_____________________________

Please indicate your method of payment, as full payment is required at the time services are rendered

Cash ❐ Check ❐ Bank Card ❐ Credit Card ❐

I understand and agree that, regardless of my insurance, I am ultimately responsible for the balance on my account for services rendered:

FOR OUR OFFICE TO SUBMIT YOUR INSURANCE AND/OR MEDICARE YOU MUST SIGN BELOW

I certify that the information given by me in applying for insurance /or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to the Eyecenters, P.A. on my behalf for any services and materials furnished. 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 payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the CMS-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

_______________________________________ ______________________

Signature Date