**Patient Information Form**

All information is strictly confidential

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last First Middle

Nickname \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street City State Zip Code

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Guardian Name (under 18) \_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Family Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| [ ] Previous Patient: \_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ] Website |  |  |
| [ ] Another Doctor: \_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Family Members Seen Here \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referral Source

|  |
| --- |
| [ ] Not of Spanish/Hispanic Origin |
| [ ] Spanish/Hispanic Origin |  |  |
| [ ] Declined to specify |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| [ ] English  |  |  | [ ] White |
| [ ] Spanish |  |  | [ ] Black/African American |  |  |
| [ ] Other: \_\_\_\_\_\_\_\_\_\_\_ |  |  | [ ] Asian  |
|  |  |  | [ ] Declined to specify |

|  |
| --- |
| [ ] White |
| [ ] Black/African American |  |  |
| [ ] Asian [ ] Other \_\_\_\_\_\_\_\_\_\_ |
| [ ] Declined to specify |

Race Preferred Language Ethnicity

 **Medical Insurance**

Required as “medical eye conditions” will be billed to your primary medical insurance

Insurance Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN of Insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group/Policy Number \_\_\_\_\_\_\_\_\_\_\_\_\_

Refraction is not covered by Medicare and must be paid by the patient at the time of service

**MEDICAL RECORDS RELEASE/PAYMENT AUTHORIZATION/LIFETIME SIGNATURE ON FILE**

**Vision Insurance**

Routine vision exams will be billed to your vision insurance

Insurance Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN of Insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group/Policy Number \_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize payment of all Medicare or other insurance benefits for services rendered by this office to be made payable either by me or on my behalf to *Lititz Eye Care, PC*.

I hereby authorize this office to release to the Health Care Financing Administration and its agents and/or to any other insurer, any information necessary to determine the benefits payable for related services. I permit a copy of this authorization to be used in place of the original. I understand that I am responsible for all charges not covered by insurance benefits.

**Patient Signature (Parent/Guardian of minor)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Birthday:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for your visit today** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ocular History

**Have YOU ever been diagnosed or treated for the following conditions?**

Cataract \_\_\_\_\_\_\_\_\_\_\_ Glaucoma \_\_\_\_\_\_\_\_\_\_\_ Macular Degeneration \_\_\_\_\_\_\_\_\_\_\_

Corneal Disease \_\_\_\_\_\_\_\_\_\_\_ Retinal Disease \_\_\_\_\_\_\_\_\_\_\_ Blindness \_\_\_\_\_\_\_\_\_\_\_

Lazy Eye \_\_\_\_\_\_\_\_\_\_\_ Eye Injury \_\_\_\_\_\_\_\_\_\_\_ **Other (specify)**  \_\_\_\_\_\_\_\_\_\_\_

Please list all previous eye surgeries \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list any family members who have been diagnosed or treated for the following conditions**

Glaucoma \_\_\_\_\_\_\_\_\_\_\_ Macular Degeneration \_\_\_\_\_\_\_\_\_\_\_ Lazy Eye \_\_\_\_\_\_\_\_\_\_\_

Blindness \_\_\_\_\_\_\_\_\_\_\_ **Other (specify)**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you currently experiencing any of the following (check all that apply)**

Blurred Vision \_\_\_\_\_\_\_ Flashes \_\_\_\_\_\_\_\_\_\_\_ Sandy/Gritty Sensation \_\_\_\_\_\_\_\_\_\_\_

Vision Loss \_\_\_\_\_\_\_ Floaters \_\_\_\_\_\_\_\_\_\_\_ Eye Pain or Soreness \_\_\_\_\_\_\_\_\_\_\_

Halos/Glare \_\_\_\_\_\_\_ Redness \_\_\_\_\_\_\_\_\_\_\_ Light Sensitivity \_\_\_\_\_\_\_\_\_\_\_

Loss of Side Vision \_\_\_\_\_\_\_ Burning \_\_\_\_\_\_\_\_\_\_\_ Swelling of Eye or Lid \_\_\_\_\_\_\_\_\_\_\_

Double Vision \_\_\_\_\_\_\_ Itching \_\_\_\_\_\_\_\_\_\_\_ Excessive Watering \_\_\_\_\_\_\_\_\_\_\_

Headaches \_\_\_\_\_\_\_ **Other (specify)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you are a contact lens wearer, please bring the contact lens prescription, or boxes.**

Medical History

**Please list your current medications (including vitamins) and dosage**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication Allergies** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous Surgeries** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have YOU ever been diagnosed or treated for the following conditions?**

High Blood Pressure \_\_\_\_\_\_\_\_ Cancer (type) \_\_\_\_\_\_\_\_ Neurological Disease \_\_\_\_\_\_\_

High Cholesterol \_\_\_\_\_\_\_\_ Migraine \_\_\_\_\_\_\_\_ Asthma/Emphysema/COPD \_\_\_\_\_\_\_

Heart Disease \_\_\_\_\_\_\_\_ Thyroid Disease \_\_\_\_\_\_\_\_ Sleep Apnea \_\_\_\_\_\_\_

Diabetes \_\_\_\_\_\_\_\_ Arthritis \_\_\_\_\_\_\_\_ Autoimmune Disease \_\_\_\_\_\_\_

Stroke \_\_\_\_\_\_\_\_ **Other (specify)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Height** \_\_\_\_\_\_\_\_\_ **Weight** \_\_\_\_\_\_\_\_\_ **Are you currently pregnant or nursing?** \_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Substance** | **Currently Use?** | **Previously used?** | **Type/Amount/Frequency** | **How Long? (Years)** | **If Stopped, When? (Year)** |
| **Tobacco** | [ ] N [ ] Y | [ ] N [ ] Y |   |   |   |
| **Alcohol** | [ ] N [ ] Y | [ ] N [ ] Y |   |   |   |
| **Recreational Drugs** | [ ] N [ ] Y | [ ] N [ ] Y |   |   |   |