

Welcome to Owensboro Family Eye Care Center

Full Name: _____ Nickname: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Gender: M F Marital Status: Single Married Other

Street Address: _____
(No P.O. Boxes)

City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____ Other/Cell Phone: (____) _____ Email: _____

Place of Employment: _____ Date of last eye exam: _____ By whom: _____

Nearest relative **not** living with you: _____ City: _____ State: _____ Phone: _____

Social Security #: _____ - _____ - _____ Family Physician: _____ City: _____

How did you hear about us?: Newspaper Radio Billboard Television Phone book Insurance Referred by: _____
(Please mark all that apply)

Activities, Sports, Hobbies: _____

Guarantor and Insurance (List Vision and Medical): Guarantor Name: _____

Guarantor Date of Birth: _____ Guarantor Social Security #: _____ - _____ - _____

Insurance Company: _____ Employer: _____

Insurance policy holders name: _____ Relationship to patient: _____

Policy holder Date of Birth: _____ Policy holder Social Security #: _____ - _____ - _____

Payment and Insurance Signature: I understand I will be responsible for payment of services and materials provided, including any associated finance charges. I request that payment of authorized Medicare, Medicaid, or any other vision/medical insurance benefits, either to me or on my behalf, be made to Owensboro Family Eye Care Center, PSC for any services rendered. I authorize Owensboro Family Eye Care Center, PSC, to release to the Health Care Financing Administration and its agent or any other insurance carrier, any information needed to determine these benefits or the benefits payable for related services. I also understand that there are no guarantees on insurance payment or quoted fees from insurances companies and that if my insurance company does not provide payment to Owensboro Family Eye Care Center, PSC, I will be responsible for payment of said services and materials. Also if any unpaid balance is assigned to a third party collection agency for collection or placed with an attorney to obtain judgment or otherwise satisfy payment of my account, a collection fee of 34% will be added to my account, and I agree to pay these fees along with reasonable attorney fees and court costs. This will stay in effect unless written documentation is given requesting that this agreement cease.

Signature: _____ **Date:** _____

HIPAA PRIVACYACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (Please **print** patient's full legal name here) _____, have been presented with a copy of the Notice of Privacy Policy of **Owensboro Family Eye Care Center, PSC** concerning my protected health information, and have been offered a copy of such policy to keep for my records.

Signature: _____ **Date:** _____

(All of the following information is kept strictly confidential for patient privacy reasons.)

Medical History

List any **Medications**, including over the counter: None _____

List any **allergies** to medicines or other? None _____

List any **major** injuries or surgeries: None _____

"Please turn form over and complete side two"

"Please turn form over and complete side two"

Are you pregnant or nursing? **Yes** **No**
 Do you wear glasses? **Yes** **No**
 Are you interested in contact lenses? **Yes** **No**

If so, pregnancy due date: _____
 Do you wear contact lenses? **Yes** **No**
 Are you interested in laser vision surgery? **Yes** **No**

Family History

Check the appropriate box if any (living or deceased) **parents, grandparents, or brothers/sisters** have the following conditions:

CONDITION	Yes	No	?	CONDITION	Yes	No	?
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crossed Eye/Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____			

Social History

Do you use tobacco products? **Yes** **No** If yes, check appropriate box: occasionally moderate use very frequently
 Do you drink alcohol? **Yes** **No** If yes, check appropriate box: occasionally moderate use very frequently
 Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis **None of these**
 Do you spend more than 3 hrs a day on a computer? **Yes** **No** Do you participate in sports? **Yes** **No**
 Do you have difficulty driving at night? **Yes** **No** Spend time or work outdoors? **Yes** **No**

Review of Systems

Check if **you** currently, or have ever had any problems in the following areas:

	YES	NO	?		YES	NO	?
CONSTITUTIONAL				EARS/NOSE/MOUTH/THROAT			
Extreme Fever or Weight Change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
INTEGUMENTARY				Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin Problems (face or neck)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL				RESPIRATORY			
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EYES				VASCULAR/CARDIOVASCULAR			
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crossed Eye/Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BONES/JOINTS/MUSCLES			
Eye Infection/Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIC/IMMUNOLOGIC			
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Immune System Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Temporary Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PSYCHIATRIC			
Itching/Burning/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression/Anxiety/Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
ENDOCRINE							
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Diabetes (Please see Vascular/Cardiovascular)							

If you have a condition not listed, please list here: _____

