Welcome to Sie Eyecare, OD, PA

The information in this confidential case history form is critical to the evaluation of your vision and health.

Today's Date _____

Patient Information

Title Rev. Dr. Mr. Mrs. Ms. (circle one)

Last _____

First _____ MI _____

Street _____

City _____ State _____

Zip Code _____

Sex M F

Home Phone _____

Work Phone _____

Cell Phone _____

Patient's SSN _____

Date of Birth _____ Age _____

Employer (or School) _____

Occupation (or Grade) _____

Spouse (or Parent's Name) _____

Email Address _____

VERY IMPORTANT! NEW PATIENTS ONLY:

Who may we thank for referring you to our office?

Name of friend or relative _____

Insurance Information

Vision Insurance _____

Subscriber Name _____

Subscriber SSN _____ ID# _____

Subscriber Birth Date _____

Primary Medical Insurance _____

Subscriber Name _____

Subscriber SSN _____ ID# _____

Subscriber Birth Date _____

Please note that contact lens fitting and evaluation fees are not usually covered as part of a routine vision examination.

Payment Policy

Payment of professional services is due upon the completion of services. Complete payment of glasses and contact lenses is due before the materials can be dispensed.

For those with insurance coverage we are happy to file these benefits for you and take assignment (which allows the insurer to pay us directly thereby avoiding you having to pay out of pocket). Please remember you are ultimately responsible for ALL charges incurred including balances NOT COVERED by or rejected by your insurance plan.We allow 60 days for insurance to pay their portion and then the bill is turned over to you for payment of the remaining balance.

Signature: _____ Date: _____

Patient Health History

Name of family Physician _____

Date of Last Physical _____

(Use the back if needed)

List current medications **(Rx or Over the Counter)**
(Including eye drops, vitamins, & birth control pills)

_____

Allergies to medications? ❑ Yes ❑ No

List _____

Have you had any surgeries? ❑ Yes ❑ No

List including year _____

_____

Do you use:

Tobacco Products ❑ Yes ❑ No

Alcohol ❑ Yes ❑ No

Have you ever been diagnosed or treated for problems with any of the following?

	Yes	No		Yes	No
Allergies	❑	❑	HIV	❑	❑
Arthritis	❑	❑	Integumentary (Skin)	❑	❑
Blood/Lymph	❑	❑	Kidney	❑	❑
Cancer	❑	❑	Liver Disease	❑	❑
Cholesterol	❑	❑	Lung	❑	❑
Diabetes	❑	❑	Muscle/Bone	❑	❑
Digestive	❑	❑	Neurological	❑	❑
Ears/Nose/Throat	❑	❑	Psychological	❑	❑
Endocrine	❑	❑	Thyroid	❑	❑
Heart Disease	❑	❑	Unusual weight	❑	❑
High Blood Pressure	❑	❑	losses/gains		

Patient Eye History

Date of Last Eye Exam _____

By Whom? _____

Have you ever tried contact lenses? ❑ Yes ❑ No

Do you currently wear contact lenses? ❑ Yes ❑ No

What is the major purpose of this visit?

_____

Any problems with your current contact lenses or glasses?

_____

Family Health History (Check all that apply)

Is there a family medical history of any of the following:

	Relationship to patient
Blindness	❑ _____
Cataracts	❑ _____
Strabismus (Lazy Eye)	❑ _____
Macular Degeneration	❑ _____
Glaucoma	❑ _____
Retinal Disease	❑ _____
Diabetes	❑ _____
Heart Disease	❑ _____
Hypertension	❑ _____
Cancer	❑ _____