PREMIER EYE CARE

WELCOME!

Please complete this form and return it to the reception desk. If you have any questions, we will be glad to help you.

Please print

PATIENT INFORMATION

Date: ____/____/____ Patient SS # _____-_____-_____

Patient Name: _____ _____ ____ _____
Last First M.I. Nickname

Street Address _____ City _____

State _____ Zip _____ E-mail Address _____

Home Phone _____-_____-_____ Work Phone _____-_____-_____ Cell Phone _____-_____-_____

Gender ☐ M ☐ F AGE _____ Birthdate ____/____/____ ☐ Married ☐ Single ☐ Widowed ☐ Minor ☐ Other

Occupation _____ Employer/School _____

EMERGENCY CONTACT : Name _____ Relationship to Patient _____

Home Phone _____-_____-_____ Work Phone _____-_____-_____ Cell Phone _____-_____-_____

INSURANCE

Who is responsible for this account? _____ _____ _____
Last First M.I.

Relationship to patient _____ Birthdate ____/____/____ SS # _____-_____-_____

Insurance Company _____ Group # _____ I.D. #_____

Any Secondary Insurance? ☐ YES ☐ NO If YES, please provide... Subscriber's Name _____

Relationship to patient _____ Birthdate ____/____/____ SS # _____-_____-_____

Insurance Company _____ Group # _____ I.D. #_____

ASSIGNMENT AND RELEASE: I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Porter 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. The aforementioned doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Patient Representative Date

_____ _____
Printed name of Patient, Parent, Guardian or Patient Representative Relationship to Patient

EYE HEALTH HISTORY

Name of previous Eye Doctor, if any _____ Date of last eye exam ____/____/____

Do you wear glasses? ☐YES ☐NO If YES, when: ☐All the time ☐Occasionally ☐Reading ☐Driving ☐TV

Do you wear contacts? ☐ YES ☐ NO Type: _____ Hours per Day: _____

Describe problems, if any, with your contacts: _____

Please check all that apply & list date of on-set:

☐_____Bloodshot eyes	☐_____Discharge from Eyes	☐_____Floaters/Spots	☐_____Red Eyes
☐_____Blurred Vision-Distance	☐_____Double Vision	☐_____Glaucoma	☐_____Seeing Halos
☐_____Blurred Vision-Near	☐_____Dry Eyes	☐_____Headaches	☐_____Seeing Flashes
☐_____Burning eyes	☐_____Eye Infection	☐_____Itching Eyes	☐_____Temporary Loss of Vision
☐_____Cataracts	☐_____Eye Injury	☐_____Light Sensitivity	☐_____Watering Eyes
☐_____Color Vision, Poor	☐_____Eye Strain	☐_____Loss of Vision	☐
☐_____Crossed Eyes	☐_____Fainting/Blackouts	☐_____Night Vision=Poor	☐_____Other: _____

GENERAL HEALTH HISTORY

Physician's Name _____ Date of last visit ____/____/____

Please mark Y for "YES" or N for "NO" to indicate if YOU or a BLOOD RELATIVE have had any of the following:

	SELF	FAMILY MEMBER
AIDS/HIV	☐Y ☐N	☐Y ☐N
Arthritis	☐Y ☐N	☐Y ☐N
Asthma	☐Y ☐N	☐Y ☐N
Blindness	☐Y ☐N	☐Y ☐N
Cancer	☐Y ☐N	☐Y ☐N
Cataracts	☐Y ☐N	☐Y ☐N
Chemical Dependency	☐Y ☐N	☐Y ☐N
Diabetes Type 1	☐Y ☐N	☐Y ☐N
Diabetes Type 2	☐Y ☐N	☐Y ☐N
Emphysema	☐Y ☐N	☐Y ☐N
Epilepsy	☐Y ☐N	☐Y ☐N
Eye Surgery	☐Y ☐N	☐Y ☐N
Glaucoma	☐Y ☐N	☐Y ☐N
Hay Fever	☐Y ☐N	☐Y ☐N
Heath Condition	☐Y ☐N	☐Y ☐N
Hepatitis (Type ____)	☐Y ☐N	☐Y ☐N

	SELF	FAMILY MEMBER
High Blood Pressure	☐Y ☐N	☐Y ☐N
Kidney Disease	☐Y ☐N	☐Y ☐N
Lazy Eye	☐Y ☐N	☐Y ☐N
Lupus	☐Y ☐N	☐Y ☐N
Migraine Headaches	☐Y ☐N	☐Y ☐N
Pacemaker	☐Y ☐N	☐Y ☐N
Poor Color Vision	☐Y ☐N	☐Y ☐N
Retinal Disease	☐Y ☐N	☐Y ☐N
Shingles	☐Y ☐N	☐Y ☐N
Skin Conditions	☐Y ☐N	☐Y ☐N
Stroke	☐Y ☐N	☐Y ☐N
Thyroid Conditions	☐Y ☐N	☐Y ☐N
Tuberculosis	☐Y ☐N	☐Y ☐N
Turned Eye	☐Y ☐N	☐Y ☐N

Tobacco Use _____ Alcohol Use_____

Are you pregnant? _____

Other Information or Explanation of any "YES" answers: _____

MEDICATIONS

List any medications you are currently taking, including eye drops:

_____ _____

_____ _____

_____ _____

ALLERGIES

List any allergies to medications or other materials/substances:

_____ _____

_____ _____

_____ _____

How did you hear about us?

☐ Friend/Family ☐ *Mimi Vanderhaven's Fabulous Buys* ☐ Drive by ☐ Phone Book

☐ Internet Search ☐ *Royalton Recorder* ☐ Insurance Referral ☐ Other, please list:

Whom may we thank for your referral?

_____