

# PALMER EYECARE CENTER

**Name** \_\_\_\_\_ **Birth Date** \_\_\_\_\_  
Mr/Mrs/Ms Last First MI MM / DD / YYYY

**Address** \_\_\_\_\_ **Social Security #** LAST 4 DIGITS \_\_\_\_\_  
Street City State Zip ↓ PLEASE CONTACT ME HERE

**Employer** \_\_\_\_\_  **Home Phone** ( ) \_\_\_\_\_

**Occupation** \_\_\_\_\_ **Marital Status** \_\_\_S\_\_\_M\_\_\_D\_\_\_W  **Work Phone** ( ) \_\_\_\_\_

**Spouse's Name** \_\_\_\_\_  **Cell Phone** ( ) \_\_\_\_\_

**Emergency Contact and Phone** \_\_\_\_\_  **Email** \_\_\_\_\_

**Primary Care Physician** \_\_\_\_\_ **City** \_\_\_\_\_ **Phone** ( ) \_\_\_\_\_

**Pharmacy** \_\_\_\_\_ **City** \_\_\_\_\_ **Phone** ( ) \_\_\_\_\_

**Guarantor** (who is paying?) \_\_\_\_\_ **Address** (if different) \_\_\_\_\_

**Sex** \_\_\_M\_\_\_F **Last Eye Exam was in 20** \_\_\_\_\_ **with Dr.** \_\_\_\_\_ **May we text you?** \_\_\_Y\_\_\_N

**Preferred Language** \_\_\_\_\_ **Preferred Communication**  US Mail  Telephone  E-mail  Text

**How did you hear about our office?** Ad in \_\_\_\_\_ Google/Internet \_\_\_\_\_ Provider Directory \_\_\_\_\_

**Referred by** \_\_\_\_\_ Newspaper/Magazine Ad \_\_\_\_\_ Doctor/Friend \_\_\_\_\_

**Race** \_\_\_ Native American/Native Alaskan \_\_\_ Hispanic  
\_\_\_ Asian \_\_\_ Native Hawaiian/Other Pacific Island \_\_\_  
\_\_\_ Black/African American \_\_\_ White \_\_\_ Not Hispanic/Latino

## Eye Care/Vision Insurance Information

(a copy will be taken of your insurance card) **Primary/Major Medical** \_\_\_\_\_ **Secondary/Vision Plan** (Prepaid Discount Eyeglass Plan) \_\_\_\_\_

**HMO/Ins. Company** \_\_\_\_\_

**Name of Policy Holder** \_\_\_\_\_

**Relationship to Insured** \_\_\_Self\_\_\_Spouse\_\_\_Dependent \_\_\_Self\_\_\_Spouse\_\_\_Dependent

## Financial Policy

You must bring your insurance card to each visit. As a courtesy, we will bill your insurance for services rendered. However, we must have all insurance and referral information provided to us BEFORE services are rendered or full payment will be required before you leave. Questions involving eligibility, deductibles, co-payments, benefits and overall coverage must be addressed with your carrier, not our office. Not all insurance plans include vision care. **In cases of multiple vision/health plan coverages, medical tests will be billed to**

**medical insurance; vision testing and vision correction devices will be billed to vision plan.** You are responsible for any fees not covered by your plan or insurance. A 1½% billing fee is added to outstanding balances over 30 days old. Accounts unpaid for 90 days are sent to collection. Patients are responsible for all costs associated with collection and/or legal actions. There is a \$29 fee for returned checks. There is a \$35 broken appointment fee for patients who fail to notify the office within 24 hours that they will miss their reserved time.

**I authorize the Palmer Eyecare Center, LLC to submit a claim to my insurance carrier and direct my insurance carrier to issue payment directly to the Palmer Eyecare Center, LLC. I authorize the release of any required medical diagnostic information to my health plan. I further assign to the Palmer Eyecare Center, LLC all rights afforded to me under ERISA with respect to the services rendered, including the right to bring an action to enforce ERISA and my ERISA rights.**

*I ACCEPT FULL FINANCIAL RESPONSIBILITY FOR ALL CHARGES AND FEES RELATED TO MY MEDICAL TREATMENT AND VISION CORRECTION DEVICES.*

## "Notice of Privacy Practices" Receipt

In the course of providing services to you, we create, receive and store identifying health information. It is often necessary to use and disclose this information in order to treat you, obtain payment for services, and to conduct healthcare operations involving our office. The "Notice of Privacy Practices" you have been given describes these uses and disclosures in detail.

*I acknowledge receiving the "Notice of Privacy Practices" from the Palmer Eyecare Center.*

\_\_\_\_\_  
**Lifetime Authorization Signature of Patient or Representative** (Specify Relationship) **Date**

Updated: \_\_\_\_\_

# PALMER EYECARE CENTER

## Patient/Family Health History

(please use another sheet if more space is needed)

Patient Name: \_\_\_\_\_ Last Physical Exam: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month / Year

Do you have special visual requirements for computers, work (safety glasses), sports (fishing), driving (night) or hobbies? \_\_\_\_\_

Do you use a:  Laptop?  Desktop?  Smartphone?

Please list all your current medications (include over the counter, vitamins and herbal therapy): \_\_\_\_\_

List any allergies to medications or anything else: \_\_\_\_\_

List all major surgeries (including eye and laser surgery): \_\_\_\_\_

Do you wear:  Eyeglasses  Contact Lenses? By the end of the day, do they  dry out  get scratchy  vision fluctuates? Do eyes get red?  Yes  No

Do you have a spare pair of glasses?  Yes  No Do you use sunglasses?  Yes  No Do you have a pair in your current prescription?  Yes  No

Do you have dry, gritty or scratchy eyes?  Yes  No Use artificial tears?  Yes  No WOMEN: Are you pregnant?  Yes  No Breast feeding?  Yes  No

Does your vision fluctuate?  Yes  No If so, does blinking help stabilize your vision?  Yes  No Do your eyes tend to look red or bloodshot?  Yes  No

### FMH

Please indicate if any of these eye or medical conditions apply (blood relatives only).

### HPI

Family Member	You	HAS ANYONE IN YOUR FAMILY EVER HAD:	Relationship	DO YOU CURRENTLY HAVE:
<input type="checkbox"/>	<input type="checkbox"/>	Blindness	_____	<input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Floaters
<input type="checkbox"/>	<input type="checkbox"/>	Cataract	_____	<input type="checkbox"/> Burning/Itching/Allergies <input type="checkbox"/> Glare/Halos Around Lights
<input type="checkbox"/>	<input type="checkbox"/>	Eye Turn/Strabismus	_____	<input type="checkbox"/> Crusty, Gritty Feeling <input type="checkbox"/> Infection of the Eye or Lid
<input type="checkbox"/>	<input type="checkbox"/>	<b>Glaucoma</b>	_____	<input type="checkbox"/> Distortion of Vision <input type="checkbox"/> Light Sensitivity
<input type="checkbox"/>	<input type="checkbox"/>	Keratoconus	_____	<input type="checkbox"/> Double Vision <input type="checkbox"/> Loss of Vision in One Eye
<input type="checkbox"/>	<input type="checkbox"/>	Lazy Eye/Amblyopia	_____	<input type="checkbox"/> Droopy Eyelids <input type="checkbox"/> Mucous Discharge from Eye
<input type="checkbox"/>	<input type="checkbox"/>	<b>Macular Degeneration</b>	_____	<input type="checkbox"/> Dry Eyes <input type="checkbox"/> Pink Eye <input type="checkbox"/> Red Eye
<input type="checkbox"/>	<input type="checkbox"/>	Retinal Detachment	_____	<input type="checkbox"/> Dyslexia/Reverses Letters <input type="checkbox"/> Puffy Lids <input type="checkbox"/> Styes
<input type="checkbox"/>	<input type="checkbox"/>	Retinal Disease	_____	<input type="checkbox"/> Eye Ache or Pain <input type="checkbox"/> Something in Eye
<input type="checkbox"/>	<input type="checkbox"/>	Cancer (Type _____)	_____	<input type="checkbox"/> Flashes of Light <input type="checkbox"/> Watery Eyes
<input type="checkbox"/>	<input type="checkbox"/>	<b>Diabetes</b>	_____	<input type="checkbox"/> Loss of Central or Side or Top or Bottom Vision
<input type="checkbox"/>	<input type="checkbox"/>	Headaches/Migraines	_____	When reading, do:
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	_____	<input type="checkbox"/> words run together? <input type="checkbox"/> you lose your place easily?
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	_____	Do you ever get car sick? <input type="checkbox"/> Yes <input type="checkbox"/> No
				Do you ever have problems seeing 3D movies? <input type="checkbox"/> Yes <input type="checkbox"/> No

### ROS Please indicate below if you now have or have ever had serious problems with the following systemic conditions or symptoms:

#### Allergic/Immunologic

- None  Lupus  Lyme Disease
- Allergies: Foods, Latex, Dust, etc.
- Autoimmune Disorder/Sjogren's
- Herpes  Sarcoid  HIV/AIDS
- Rheumatoid Arthritis  Hives
- Other \_\_\_\_\_

#### Ear, Nose and Throat

- None  Chronic Cough
- Dental or Mouth Problems
- Nose Bleeds  Sore Throat
- Ringing in Ears/Tinnitus
- Sinusitis  Hearing Loss
- Other \_\_\_\_\_

#### Gastrointestinal

- None  Diarrhea
- Acid Reflux  Ulcers
- Heartburn  Vomiting
- IBD/Colitis/Crohn's
- Liver Disease/Hepatitis
- Other \_\_\_\_\_

#### Skin/Integumentary

- None  Dermatitis
- Eczema/Psoriasis
- Itchiness/Dryness/Rashes
- Pimples/Warts/Growths
- Rosacea/Impetigo/Acne
- Other \_\_\_\_\_

#### Psychiatric

- None  ADHD
- Anxiety/Depression/Stress
- Bi-Polar  Memory Loss
- Panic Episodes  Dementia
- Schizophrenia  Alzheimers
- Other \_\_\_\_\_

#### Cardiovascular

- None  Stroke  Angina
- Hypertension  Heart Attack(MI)
- Heart Disease  Arrhythmia
- High Cholesterol
- Vascular Disease
- Other \_\_\_\_\_

#### Endocrine/Glands

- None  Hyper/Hypoglycemia
- Diabetes  Gout
- Hormone Disorder
- Pituitary Disorder
- Thyroid Disorder
- Other \_\_\_\_\_

#### Respiratory

- None  TB  Cystic Fib
- Asthma/Bronchitis
- Sleep Apnea  Sarcoid
- Emphysema  COPD
- Upper Respiratory Inf.
- Other \_\_\_\_\_

#### Muscle/Skeletal

- None  Arthritis
- Ankylosing Spondylitis
- Fibromyalgia/Polymyalgia
- Gout  Joint/Muscle Pain
- Muscular Dystrophy
- Other \_\_\_\_\_

#### Genital/Urinary

- Bladder Problem
- Blood in Urine  Menopause
- Herpes/Chlamydia
- Kidney Disease  Prostate
- Urinary Tract Infection
- Other \_\_\_\_\_

#### Hematologic/Lymphatic

- None  Anemia
- Bruises Easily  Sick Cell
- Bleeding or Blood Disorder
- Leukemia/Lymphoma
- Swollen Glands
- Other \_\_\_\_\_

#### Neurological

- None  Bell's Palsy  Stroke
- Cerebral Palsy  Epilepsy
- Migraines  MS  Vertigo
- Numbness/Weakness  TBI
- Tremors/Seizures/Blackouts
- Other \_\_\_\_\_

#### Constitutional/General Health

- Good Overall  Fainting
- Dizziness  Fatigue
- Fever/Chills  Insomnia
- Nausea  Nosebleeds
- Rapid Weight Loss/Gain
- Thirsty  Sweats
- Other \_\_\_\_\_

#### Social

- Tobacco Use:  Former Smoker Quit When? \_\_\_\_\_ yrs ago  
 Current Smoker #/day \_\_\_\_\_ For \_\_\_\_\_ years
- Recreational Drugs \_\_\_\_\_
- Alcohol Consumption \_\_\_\_\_ drinks/day
- Exercise:  Regularly  Occasionally  Rarely
- Weight \_\_\_\_\_ Height \_\_\_\_\_

Please sign below and initial annually to acknowledge that this form is current:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Reviewed by Doctor's initials: \_\_\_\_\_

Updated: \_\_\_\_\_