EliteEyeCare

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WELCOME TO OUR OFFICE

NAME: DATE:

DO YOU EXPERIENCE, BEEN DIAGNOSED, OR TREATED FOR...(CHECK BOX FOR YES)

□ BLURRY VISION	□ GRITTINESS	□ CATARACTS	□ EYE INJURY	□ UNCOMFORTABLE GLASSES
□ BURNING EYES	□ ITCHY EYES	□ GLAUCOMA	□ CORNEAL ABRASION	□ DIABETIC RETINOPATHY
□ TEARING	□ BLEPHARITIS	□ HEADACHES	□ FLOATERS/SPOTS	□ MACULAR DEGENERATION
□ DRY EYE DISEASE	□ IRITIS/UVEITIS	□ FLASHES OF LIGHT	□ POOR NIGHT VISION	□ RETINAL DETACHMENT
□ EYE INFECTION	□ DOUBLE VISION	□ LIGHT SENSITIVITY	□ LAZY EYE	□ RED EYE RELATED TO CONTACT LENSES

Has Anyone in your family been treated for…..
BLINDNESS □ _____CATARACTS □ _____GLAUCOMA □ _____DIABETES □ _____
LAZY EYE □ _____ MACULAR DEGENERATION □ _____HIGH BLOOD PRESSURE □ _____
RETINAL PROBLEMS □ _____ OTHER (PLEASE SPECIFY) □ _____

PERSONAL HEALTH HISTORY:

FAMILY PHYSICIAN:_____CLINIC:_____DATE OF LAST PHYSICAL:_____

ARE YOU TAKING ANY PRESCRIPTION MEDICATION? □ Y □ N LIST_____

ARE YOU TAKING NON-PRESCRIPTION MEDICATION? □ Y □ N LIST_____

DO YOU HAVE ANY MEDICAL ALLERGIES? □ Y □ N LIST_____

DO YOU USE: CIGARETTES/TOBACCO □ Y □ N ALCOHOL □ Y □ N OTHER SUBSTANCES? □ Y □ N

HAVE YOU HAD ANY MAJOR SURGERIES? □ Y □ N TYPE OF SURGERY_____DATE_____

HAVE YOU EVER BEEN TREATED FOR THE FOLLOWING HEALTH PROBLEMS? IF YES, PLEASE EXPLAIN

CONSTITUTIONAL (dev. disability, fever, weight loss, fatigue)	□ Y □ N	_____
EAR/NOSE/THROAT/MOUTH (hearing loss, URT infection)	□ Y □ N	_____
NEUROLOGIC (multiple sclerosis, epilepsy)	□ Y □ N	_____
PSYCHOLOGICAL	□ Y □ N	_____
CARDIOVASCULAR (heart, high blood pressure, stroke)	□ Y □ N	_____
RESPIRATORY	□ Y □ N	_____
GASTROINTESTINAL (Crohn's, colitis, ulcer, digestive)	□ Y □ N	_____
GENITOURINARY (kidney disfunction, prostate/ovarian cancer)	□ Y □ N	_____
MUSCLES/JOINTS (osteoarthritis, weakness)	□ Y □ N	_____
SKIN (eczema, rosacea, rash, dryness)	□ Y □ N	_____
ENDOCRINE (diabetes, hyper– or hypo-thyroid)	□ Y □ N	_____
BLOOD (anemia/leukemia)	□ Y □ N	_____

PRIVACY PRACTICES ACKNOWLEDGEMENT AND INSURANCE PAYMENT AUTHORIZATION

I acknowledge that I have received a copy of the Notice of Privacy Practices of Elite Eye Care to review. I also authorize the payment of any eye care benefits or medical insurance to my Doctor of Optometry for goods or services rendered. I permit a copy of this authorization to be used in place of the original signature and authorize release of medical information necessary to pay the claim. I understand that I may have co-payments, deductibles, and overage costs, and ultimately I am responsible for all fees incurred, and that payment is expected at the time of service or at the time of ordering . If I have Medicare, I understand that my signature request payment of authorized Medicare benefits be made on my behalf to Elite Eye Care, for any goods/services furnished to my by that physician/supplier.

NAME:_____ **SIGNATURE:**_____ **DATE:**_____

(PARENT/GUARDIAN IF UNDER 18)