CONFIDENTIAL PATIENT INFORMATION

PATIENT INFORMATION

Full Name_____ Phone # (Home) _____ (Day) _____

Nickname_____ (Cell #) _____Language_____

Date of Birth_____ Race_____Ethnicity_____

Social Security Number_____ E-mail address_____

Address_____ M/F_____Marital status_____

City_____State_____Zip_____ Reminders by mail, phone, text, or e-mail._____

INSURANCE AND FINANCIAL INFORMATION

Medical insurance carrier(s)_____ Employer_____

Vision insurance_____ Other insurance_____

Name of insured person (if not patient)_____

Birthdate of insured_____ SSN of insured_____

Person responsible for account (if not patient)_____

REQUEST AND RELEASE OF INFORMATION

I understand that Drs. Reeves and Stoppel (this Practice) will contact my Medicare/Medicaid/Other insurance carrier regarding coverage of services provided to me. I authorize my physician and other medical entities to release my confidential medical information to this Practice concerning my medical history. I authorize this Practice to release my confidential medical information to my health insurance carrier to facilitate reimbursement for my medical fees, to my physician and to other medical entities for coordination of care. _____ initial

AUTHORIZATION TO ASSIGN BENEFITS

I assign and authorize Medicare/Medicaid/Other insurance payments to this Practice for goods and services provided to me. I understand it is mandatory to notify this practice of any other party who may be responsible for paying for my treatment. I permit a copy of this authorization be used in place of the original. _____ initial

PRIVACY PRACTICES

I acknowledge that the Notice of Privacy Practices has been made available to me. _____ initial

_____

Signature of Patient, Parent, Guardian or Responsible Party ***Date***

_____

Print Name of Patient, Parent, Guardian or Responsible Party ***Relationship to Patient***

GENERAL HISTORY

Date of last eye exam_____ Occupation_____

Previous eye doctor_____ Hours spent on computer per day_____

Name of medical doctor_____ Hobbies_____

Date of last medical exam_____ Special visual needs_____

Please turn over and complete side two*

Circle any of the following about which you are interested or have questions:

Allergy care ***Contact lenses*** ***Low vision*** ***Cataract surgery*** ***LASIK*** ***Sports vision***

YOUR MEDICAL HISTORY

Are you pregnant and/or nursing? Yes ☐ No ☐

List any medications *(Omit this if you brought a list)*

List any medication allergies or contact solution allergies

_____ _____

_____ _____

_____ _____

List all major injuries, surgeries, and/or hospital stays _____

_____ List any Eye drops or Medications for your eyes

_____ _____

YOUR EYE HISTORY

Circle any of the following that apply to you now or in the past:

Bleeding in eye ***Eye infection*** ***Lazy eye*** ***Cataract*** ***Eye injury*** ***Macular degeneration***

Crossed eyes ***Eye surgery*** ***Prominent eyes*** ***Drooping eyelid*** ***Glaucoma*** ***Retinal disease***

Others not listed above or details of the above: _____

Do you wear glasses? Yes ☐ No ☐ Do you wear contact lenses? Yes ☐ No ☐

When did you last get glasses? _____ What type/prescription of contacts?_____

Are they working well? Yes ☐ No ☐ Are they comfortable? Yes ☐ No ☐

FAMILY EYE HISTORY

Circle any of the following that apply to members of your immediate family and indicate relationship besides the condition (parents, grandparents, siblings, and children):

Blindness ***Crossed eyes*** ***Retinal detachment*** ***Cataract*** ***Glaucoma*** ***Color blindness*** ***Macular degeneration*** ***Other (specify)***

YOUR SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Do you drive? Yes ☐ No ☐ What visual difficulties do you have while driving? _____

Do you use tobacco or smoke? Yes ☐ No ☐ What type/amount/how long? _____

Do you drink alcohol? Yes ☐ No ☐ What type/amount/how long? _____

Do you use illegal or recreational drugs? Yes ☐ No ☐ What type/amount/how long? _____

Circle any of the following to which you have been exposed: ***Gonorrhea*** ***HIV/AIDS*** ***Hepatitis*** ***Syphilis***

Doctor signature _____ Date _____