# PATIENT INFORMATION RECORD
# (PLEASE PRINT) (Must be reviewed each year)

**TODAY'S DATE__________________REVIEWED DATE:____________ ____________ ____________ ____________**

**MR.___MRS.___MISS___MS.___DR.___PATIENT'S NAME______________________________________________**
**(First) (MI) (Last)**

**ADDRESS________________________________________Apt#________CITY______________________ST______ZIP___________**

**PHONE # (___)__________________________(___)____________________________Dept./Ext.__________(___)____________________**
**(Home) (Work) (Pager/cell)**

**SOCIAL SECURITY #_______-________-_______ MALE ______FEMALE_______DATE OF BIRTH__________________________**

**PATIENT STATUS: MARRIED___SINGLE___WIDOW___DIVORCED___OTHER______ EMPLOYED/STUDENT/RETIRED**
**(Circle one)**

**EMPLOYER/SCHOOL NAME: __________________________________________________Occupation_________________________**

**HOW DID YOU HAPPEN TO COME TO THIS OFFICE? (CHECK ALL THAT APPLY) Internet____ A Doctor____________**

**Saw our Sign______ Insurance List_____ A Friend/Relative (name)____________________________ Other________________________**

**Email Address: ____________________________________________**

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## PATIENT MEDICAL INFORMATION

**WHAT EYE PROBLEMS ARE YOU HAVING? ______________________________________________________________________**
**__________________________________________________________________________________________________**
**__________________________________________________________________________________________________**

**WHEN WAS YOUR LAST EYE EXAMINATION? ______________PREVIOUS EYE DOCTOR? ______________________________**

**DO YOU NOW OR HAVE YOU EVER WORN ( ) GLASSES ( ) CONTACT LENSES**

**ARE YOU INTERESTED IN CONTACT LENSES TODAY? ( ) YES ( ) NO**

**Please check box if applicable & provide details.**

1. **PAST EYE HISTORY:** **EXPLANATION: (WHEN?)**

**( ) INJURY ( ) TUMOR ( ) SURGERY ( ) CROSSED EYE** ______________________________________
**( ) DISEASE ( ) AMBLYOPIA(LAZY EYE) ( ) DRY EYES** ______________________________________
**( ) CATARACTS ( ) RETINA PROB. ( ) GLAUCOMA** ______________________________________
**( ) NO PREVIOUS INJURY/DISEASE ( ) OTHER** ______________________________________

2. **LIST ALL MEDICATIONS AND VITAMINS YOU ARE TAKING**
______________________________________________________________________________
______________________________________________________________________________

3. **ARE YOU ALLERGIC TO ANY MEDICATIONS? ( ) YES ( ) NO**
**IF YES, WHICH ONES/WHAT HAPPENS? ______________________________________________________________________**

**PRIMARY CARE PHYSICIAN: ______________________________________________ Date of last visit______________________**

4. **YOUR PAST MEDICAL HISTORY: (Check box if applicable & provide details. ) EXPLANATION: (WHEN?)**

**( ) DIABETES ( ) SURGERY ( ) BACK/NECK DISORDERS** ______________________________________
**( ) ENDOCRINE (GLANDS) ( ) NEUROLOGICAL DISORDERS** ______________________________________
**( ) STROKE ( ) CANCER ( ) RESPIRATORY DISORDERS** ______________________________________
**( ) HIGH BLOOD PRESSURE ( ) VASCULAR DISORDER** ______________________________________
**( ) HEART DISORDERS ( ) EMOTIONAL DISORDERS** ______________________________________
**( ) URINARY DISORDERS ( ) ARTHRITIS** ______________________________________
**( ) THYROID CONDITION ( ) HIGH CHOLESTEROL** ______________________________________
**( ) ALLERGIES ( ) OTHER ( ) HIV/ AIDS** ______________________________________
**( ) USE OF NICOTINE ( ) USE OF ALCOHOL ( ) OTHER DRUGS**

**RATE YOUR GENERAL HEALTH:_________________________________**

5. **YOUR FAMILY EYE HISTORY: (Check box if applicable & provide details.) EXPLANATION: (MOTHER, FATHER, ETC.)**

**( ) GLAUCOMA ( ) DIABETES ( ) CROSSED EYE** ______________________________________
**( ) EYE CANCER ( ) CATARACT ( ) RETINA PROBLEMS** ______________________________________
**( ) HIGH BLOOD PRESSURE ( ) OTHER** ______________________________________

# PLEASE COMPLETE INFORMATION ON BACK SIDE OF FORM

# PATIENT INSURANCE INFORMATION

**VISION INSURANCE CO. NAME:** ____________________

**INSURED NAME:** ____________________ **INSURED D.O.B** ____________________

**EMPLOYER** ____________________ **RELATIONSHIP TO PATIENT** ____________________

**IDENTIFICATION #** ____________________ **GROUP#** ____________________ **INSURED_SSN:** ____________________

**Vision Insurance Disclaimer:** **Would you like your personal medical information shared with your vision carrier?**
**YES** ________ **NO** ________ **(Recommended)**

**MEDICAL INSURANCE:**

**MEDICARE: TRICARE: MEDICAID: ANTHEM: CIGNA: UHC: AETNA:**
**OTHER INSURANCE:** ____________________

**INSURED NAME:** ____________________ **POLICY #** ____________________ **INSURED D.O.B.** ____________________

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## WHO IS RESPONSIBLE FOR THE PATIENT DUE BALANCE?

**Relationship to Patient: Self _____ Spouse _____ Father ____ Mother _____ Other ____________________**

(**REQUIRED** IF PATIENT IS UNDER 18 YEARS OF AGE OR SOMEONE OTHER THAN THE PATIENT IS RESPONSIBLE)

**NAME:** ____________________
**(First) (MI) (Last)**

**ADDRESS:** ____________________
____________________

**OCCUPATION:** ____________________

**DOB:** ____________________

**SSN:** ____________________

**HOME PHONE:** ____________________

**WORK/CELL:** ____________________

**EMPLOYER:** ____________________

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## PATIENT'S/INSURANCE AUTHORIZATION AND ASSIGNMENT

**I authorize Drs. Seim and Batac to furnish information to insurance carriers including Social Security Administration or its intermediaries of carrier, concerning my illness and treatment. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party that accepts assignment. I understand that my insurance is a contract between me and my insurance carrier. I UNDERSTAND THAT I AM RESPONSIBLE FOR THIS ACCOUNT. I understand that if Drs. Seim, and Batac do not receive a response from my insurance company within 60 days of filing my claim, I am responsible for payment of this account in full. I understand that I am responsible for any amount not covered by insurance. In the event that my check is returned for non-sufficient funds, I agree to pay a $35.00 fee. We may electronically debit or draft your account for this charge. Also, if your check is returned for insufficient or uncollected funds, your check may be electronically re-presented for payment.**

**X**

**(DATE) (PATIENT/GUARANTOR) (RELATIONSHIP TO PATIENT)**

**THIS OFFICE MAINTAINS YOUR PATIENT RECORDS FOR AT LEAST 5 YEARS FROM LAST DATE OF PATIENT ENCOUNTER. AFTER THAT TIME, THIS OFFICE MAY DESTROY YOUR RECORDS IN A MANNER WHICH PROTECTS PATIENT CONFIDENTIALITY.**

Revised 09/23/2013