EYECARE CENTER
OF WHEELING

Patient Application

Patient Information

				Date of Birth	Today's Date	
Patient Name (First, Middle, Last)	Suffix (Jr.,Sr.)	Salutation (Mr.,Ms.)	Social Security #	Birth State	Sex	Age
Address (Home, Billing Address, Office/Business - circle)		City, State , Zip		Country United States		
Home Phone	Cell Phone	Work Phone / Ext	Email Address	Preferred Communication (Cell, Email)		
Special needs						
Primary Language	Marital Status	Maiden Name		Mother's Maiden Name		
Gender Identity (Male, Female, Male-to-female transsexual, Female-to-male transsexual)		Sexual Orientation (Straight, Bisexual, Homosexual, Other, Don't Know)				
Race	Race 2	Ethnicity	Ethnicity 2			
Employer		Occupation				

Responsible Party Information

Responsible Party's Name (Salutation, First, Middle, Last)	Date of Birth	Home Phone	Cell Phone	Work Phone / Ext
Address (Street, City, State, ZIP)		Email Address	Social Security #	Gender

Primary Insurance

Insured's Name	Date of Birth	ID Number
Insurance Company Name		Insurance Co. Phone
Insurance Company Address		
Group Name	Group Number	

Secondary Insurance

Insured's Name	Date of Birth	ID Number
Insurance Company Name		Insurance Co. Phone
Insurance Company Address		
Group Name	Group Number	

Firm/Organization/Name	Phone	Address	Contact Person

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PATIENT HISTORY FORM

NAME: _____

Last First M. I.

Birthdate: ____/____/____

Reason for today's clinic visit:

Please list any concerns you have about your eyes or vision:

Last Eye Exam: Dr. or location

Last Physical Exam: Dr. or location

CURRENT MEDICATIONS

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug	**Dose (include strength & number of pills per day)**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

Drug allergies: ❑ No ❑ Yes To what?

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Stroke
- ❑ Heart problems
- ❑ Cancer (type)_____
- ❑ Arthritis
- ❑ Thyroid problems
- ❑ Liver Problems
- ❑ Kidney Problems
- ❑ Cataracts
- ❑ Glaucoma
- ❑ Macular Degeneration
- ❑ Crossed Eyes/Strabismus
- ❑ Contact Lens Wear
- ❑ Eye Sx
- ❑ Eye Injury

Family Ocular Medical Hx:

- ❑ Diabetes
- ❑ Hypertension
- ❑ Stroke
- ❑ Heart
- ❑ Cataracts
- ❑ Glaucoma
- ❑ Macular Degeneration
- ❑ Strabismus

Any other patient/family general medical or ocular conditions (please list):

Do you drink alcohol? Yes ❑ No ❑	Do you use tobacco? Yes ❑ No ❑	Are you pregnant? Yes ❑ No ❑
Servings per week	If yes, how much?	Are you nursing? Yes ❑ No ❑

Do your hobbies or work put you at risk of an eye injury?

Do you have problems in the following areas?

General Health	Yes ❑ No ❑	Genital/Urinary	Yes ❑ No ❑	Blood or Lymphatic	Yes ❑ No ❑
Ears/Nose/Throat	Yes ❑ No ❑	Skin	Yes ❑ No ❑	Allergies/Immunology	Yes ❑ No ❑
Cardiovascular	Yes ❑ No ❑	Musculoskeletal	Yes ❑ No ❑	Endocrine	Yes ❑ No ❑
Respiratory	Yes ❑ No ❑	Neurological	Yes ❑ No ❑	Psychiatric	Yes ❑ No ❑
Gastrointestinal	Yes ❑ No ❑				

Attending (Initials):

The EyeCare Center of Wheeling

Patient :

AUTHORIZATIONS- PLEASE READ CAREFULLY

SERVICE AND FEES: I hereby consent to the examination and treatment that the provider feels is necessary for rendering good vision care. I understand that the services I receive will only be performed when felt necessary and that some of these services may not be covered by my insurance. I understand I will be responsible for payment in full for all such services not covered by my insurance.

Note: There will be a $25.00 fee charged for missed appointments.

PERMISSION TO FILE INSURANCE CLAIMS AND FOR DIRECT PAYMENT OF INSURANCE:
I authorize The EyeCare Center of Wheeling to file claims to my insurance provider on my behalf.

PERMISSION FOR DIRECT PAYMENT OF INSURANCE BENEFITS: I authorize my insurance provider to make payments on my behalf directly to The EyeCare Center of Wheeling.

NOTICE OF PRIVACY PRACTICES (HIPAA): I understand that The EyeCare Center of Wheeling and its affiliated clinics may share my health information for treatment, billing, and healthcare operations.

Signature of Patient (or Legal Representative) Date

If signed by legal representative, relationship to patient:_____