PATIENT INFORMATION

Patient Name ____

Patient Date of Birth / / Sex: M/F Phone # ______________ Home/Cell/Work

Address ____

City ______________________________ State ________ Zip __________

Email ______________________________ May we text reminders? YES/NO

How did you hear about us? ______________________________

INSURANCE INFORMATION

Medical Insurance Name ______________________________

Name of insured ______________________________ Insured last 4 SS#__________

Insured DOB / / Insured's Employer ______________________________

What is the primary purpose of this visit?

____

Do you wear: ☐ **Glasses** ☐ **Soft Contacts** ☐ **RGPs**

How often do you replace your contacts?

☐ Daily ☐ Bi-weekly ☐ Monthly

Date of last eye exam (approximate) _____________

Have you ever been diagnosed with the following?

☐ Cataracts ☐ Glaucoma ☐ Lazy Eye/Amblyopia
☐ Macular Degeneration ☐ Dry Eye ☐ Eye Injury
☐ Retinal Detachment ☐ Keratoconus

CURRENT MEDICATIONS

LIST:______________________________

Allergic to any medications? Yes/No

If yes, please list:

____

Do you use cigarettes/tobacco? Yes/No

Do you drink alcohol? Yes/No

Are you pregnant or nursing? Yes/No

PATIENT HEALTH HISTORY

Have you been diagnosed or treated for any of the following: *(Please Circle)*

- ☐ **Eye** (Cataracts, Macular Degeneration, Glaucoma)
- ☐ **Cardiovascular** (Blood Pressure, Cholesterol)
- ☐ **Endocrine** (Diabetes, Thyroid)
- ☐ **Genitourinary** (Genitals, Kidney, Bladder)
- ☐ **Ears/Nose/Throat** (Sinus, Cough, Dry mouth)
- ☐ **Blood** (HIV, Sickle Cell, Anemia)
- ☐ **Gastrointestinal** (Ulcers, Reflux, Crohn's)
- ☐ **Skin** (Rash, Eczema, Cancer)
- ☐ **Muscle/Bone** (Arthritis, Fibromyalgia)
- ☐ **Neurological** (Seizures, Migraines)
- ☐ **Psychiatric** (Depression, Anxiety, ADHD)
- ☐ **Lungs** (Asthma, Bronchitis, COPD)

Other medical conditions: ____________________

FAMILY EYE HISTORY & RELATIONSHIP

- ☐ **Macular Degeneration**____________________
- ☐ **Glaucoma**______________________________
- ☐ **Other**

____

☐ I would like to have the Clarus Retinal Photo performed for a $39 co-pay. *(Doctor Recommended)*

☐ I would like to have my eyes dilated today. (Side effects include light sensitivity and blurred vision)

I have been given the opportunity to obtain a copy of the HIPAA privacy rules from this provider (available online at coppervieweyecare.com). As a courtesy, Copper View Eye Care may file claims to my insurance carrier. If I do not have insurance, it is required that I pay in full at the time of service. I understand it is my responsibility to pay any co-pay, deductible or other balance not paid by my insurance. I understand co-pays and deductibles are due at the time of service. In the event of non-payment, I am responsible for all collection costs, collection agency fees (of up to 50%) with or without suit, and attorney fees.

Patient, parent or responsible party: ______________________________ **Date:** ____________________