PHILLIPS EYE CLINIC

Welcome to our Office

Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Please review and complete all areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female ☐ New ☐ Returning

First Name ____ MI ____ Last Name ____ Preferred Name ____

Street Address ____ City ____ State ____ Zip Code ____

Social Security ____ Date of Birth ____ Primary Phone ____ Secondary Phone ____

Email Address ____ Name of Guardian or Account Responsibility ____

PRIMARY INSURANCE INFORMATION

Name of Primary Insurance ____ Insured's ID# (Social Security) ____ Group Number ____

☐ M ☐ F Insured's First Name ____ MI ____ Insured's Last Name ____ Insured's Date of Birth ____

Patient Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status

☐ Single ☐ Married ☐ Other

SECONDARY INSURANCE INFORMATION

Name of Primary Insurance ____ Insured's ID# (Social Security) ____ Group Number ____

☐ M ☐ F Insured's First Name ____ MI ____ Insured's Last Name ____ Insured's Date of Birth ____

Patient Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status

☐ Single ☐ Married ☐ Other

PLEASE READ

In order to control cost of billing, we ask the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in the office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks. Payment from my insurance is to be paid directly to Phillips Eye Clinic. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Signature ____ Date ____

PATIENT HISTORY AND INFORMATION

Health History

What is your main reason for today's exam? ____________________

When was your last eye exam? ____________________ When was your last health exam? ____________________

Past Illness or Injuries: ____________________ ____________________

Past Surgeries: ____________________ ____________________

Current Medications: ____________________ ____________________

____________________ ____________________

Current Eyedrops: ____________________ ____________________

____________________ ____________________

Medines that cause reactions or sensitivities: ____________________

Specific Allergies: ____________________

General Health Condition

Condition		
Cardiovascular *(High blood pressure etc.)*	☐ Y	☐ N
Neurological *(Multiple Sclerosis etc.)*	☐ Y	☐ N
Diabetes	☐ Y	☐ N
Allergies	☐ Y	☐ N

Eye Health History

Condition		
Glaucoma	☐ Y	☐ N
Cataract	☐ Y	☐ N
Macular Degen.	☐ Y	☐ N
Retinal Detacn.	☐ Y	☐ N

Family History

Condition		
Amblyopia *(Lazy Eye)*	☐ Y	☐ N
Blindness	☐ Y	☐ N
Cataract(s)	☐ Y	☐ N
Glaucoma	☐ Y	☐ N
Diabetes	☐ Y	☐ N
Macular Degen.	☐ Y	☐ N
Retinal Detach.	☐ Y	☐ N
Heart Disease	☐ Y	☐ N
High Blood Pressure	☐ Y	☐ N

Occupation: ____________________ **Hobbies:** ____________________

Spectacle Lens History

Do you currently wear glasses? ☐ Y ☐ N Since? ____________________

Type of Glasses: ☐ Full time ☐ Part time ☐ Distance ☐ Near ☐ Computer

Glasses Owned: ☐ Single Vision ☐ Bifocals ☐ Trifocals ☐ Progressive ☐ Safety ☐ Sports ☐ Backup

Do you own a 2nd pair of glasses? ☐ Y ☐ N Type of 2nd pair: ☐ Sunglass ☐ Computer ☐ Safety

Do you have glare problems? ☐ Y ☐ N Do you have visual difficulty when driving? ☐ Y ☐ N

Contact Lens History

Do you currently wear contact lenses? ☐ Y ☐ N If no, are you interested in contact lenses today? ☐ Y ☐ N

Type & Brand of Contact Lenses: ____________________ Since? ____________________

Disposal Schedule: ☐ Daily ☐ Bi-weekly ☐ Monthly Do you sleep in your contact lenses? ☐ Y ☐ N

HIPPA COMPLIANCE ACKNOWLEDGEMENT OF RECIEPT

I acknowledge that I received a copy of Phillips Eye Clinic's Notice of Privacy Policies.

____________________ ____________________

Patient Signature (Guardian) Date