PATIENT INFORMATION

Please check the information on this report for accuracy.
Please make corrections and fill in any missing information. Thank you in advance for your cooperation.

NAME:			
ADDRESS			
CITY, STATE, ZIP:			
HOME PHONE:		**CELL PHONE:**	
WORK PHONE:			
BIRTHDATE:		**MARITAL STATUS:**	
SOCIAL SECURITY#:			
OCCUPATION/GRADE:			
EMPLOYER/SCHOOL:			
EMAIL ADDRESS:			

INSURANCE INFORMATION

(Print Below) Insured Name	**Insured Social #**	**Date of Birth**
	--	--
Primary:		
Secondary:		
Vision:		

INSURANCE AUTHORIZATION

I request that payment of authorized Insurance benefits for any services furnished me, be made on my behalf to: HENDERSONVILLE EYE CARE OD, PA

I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits payable for related services.

I understand that I am responsible for charges not paid by the insurance plan.

X_____ _____
Responsible Party (Relationship) Date

ACKNOWLEDGEMENT OF INSURANCE & PAYMENT POLICIES

We do not participate with all insurance companies. If your insurance is one of these, payment will be expected when services are rendered. Hendersonville Eye Care will file a courtesy claim for insurance companies we participate with according to our contracts, however if the claim is denied or no payment is received from your insurance company within 30 days, the balance remaining will be transferred to you. ***You, the patient, will be responsible for payment within 30 days to Hendersonville Eye Care.***

I acknowledge that I have been advised of and understand this policy.

X_____ _____
Responsible Party (Relationship) Date

Name:_____**Date of Birth:**_____ **Age:**_____

Name of Physician:_____**Physician Phone:**_____

REVIEW OF SYSTEMS

Do you have, or have you had, any problems in the following areas? If "yes" provide information.

	YES	NO	EXPLANATION OF PROBLEMS/MEDICATIONS
Allergies	○	●	
Allergies to Medications	○	●	
Hay Fever	○	●	
Sinus	○	●	
Asthma	○	●	
Skin	○	●	
Cardiovascular(heart,blood pressure)	○	●	
Hematologic/Lymphatics	○	●	
Blood/Lymph Notes	○	●	
Respiratory (Lungs)	○	●	
Breathing	○	●	
Ear/Nose/Throat/Dental	○	●	
Gastrointestinal (stomach, hepatitis)	○	●	
Genitourinary (genitals, kidney, bladder)	○	●	
Musculoskeletal	○	●	
Muscle, Bone, Joint Pain	○	●	
Neurological (brain, spine, nerves)	○	●	
Mental/Emotional Condition	○	●	
Endocrine (diabetes, thyroid problems)	○	●	
Cancer	○	●	
General Health	○	●	
Eyes	○	●	
Burning, gritty or itchy eyes	○	●	
Pain-shooting, throbbing, aching	○	●	
Flashing Lights/Floating Spots	○	●	
Poor Night Vision	○	●	
Lazy eyes or Crossed eyes	○	●	
Eyes Examined Before?	○	●	When? Glasses? Yes/No
Eye Diseases	○	●	
Eye Injury	○	●	
Eye Surgery	○	●	

PAST HISTORY, LAST 5-10 YEARS

List all MAJOR ILLNESSES OR INJURIES:_____

_____

List all MAJOR SURGERIES: _____

_____

List ALL MEDICATIONS you take:

Medication	Strength	How Often	For what condition? Why?

FAMILY HISTORY

	YES	NO	RELATIONSHIP TO PATIENT
Blindness	○	●	
Glaucoma	○	●	
Macular Degeneration	○	●	
Retinal Detachment	○	●	
Diabetes	○	●	
Thyroid	○	●	
Heart Problems	○	●	
High Blood Pressure	○	●	
Other	○	●	

SOCIAL HISTORY

Current Occupation: _____

What special vision needs do you have?(computer etc.) _____

Hobbies: _____

Do you drive?	○ YES	● NO
Do you drink alcohol?	○ YES	● NO
Do you use tobacco products?	○ YES	● NO
Have you ever been infected with a sexually transmitted disease?	○ YES	● NO

Clicking this button will open your email client to send completed Document

Submit Information