Patient Information Date________________

Name____ **Preferred Name**______________________
Last First M.I.

Address____ **Date of Birth**__________________
Street

____ **Home Phone**__________________
City, State, ZIP **Work Phone**__________________

Occupation/Employer______________________________ **Email**__________________________________

Guardian (if under 18)______________________________ **Relationship to Patient**______________________

Insurance Authorization and Release of Information

Insurance Provider.______________________Insurance member's name_________________________
Member's Employer_________________________Member's date of birth_________________________

I authorize Steven P. Consoer / Eyecare Clinic to bill my insurance carrier on my behalf. I request that payment of authorized insurance benefits be made to this clinic for any services furnished by thedoctor/clinic. I authorize release of medical information about me to my Medical Insurance Carrier needed to determine the benefits payable for related service for myself and/or dependents. I understand that I am financially responsible for all co-payments, deductibles, or amounts not covered by my insurance carrier.

I further authorize the release of medical information regarding myself/my dependents to my referring, consulting, or treating physicians.

We may use/disclose medical information to contact you in regard to an appointment, treatment options, exam results or services that may be in interest to you. We may call you in regard to your appointment and treatment results and if necessary, leave messages on your answering machine.

Patient/Guardian Signature_______________________________________

Co

Consent for Treatment

I voluntarily consent to evaluation, treatment, diagnostic testing and /or therapy, which may include eye drops, that my doctor determines to be necessary.

Patient/Guardian Initials________________

VSP Account Information (only if applicable)

Subscriber/Member name____________________________ DOB______________ SSN (last 4)__________

Eye History

Last Eye Exam________________
Do you wear glasses? __Yes ___No I wear them for: ___reading ___distance ___both

Do you wear contact lenses? ___Yes ___No, Overnight/Extended wear ___Yes ___No
If No, do you have an interest in wearing/restarting contacts? ____Yes

Do you have any interest in refractive surgery? (LASIK/PRK) ___Yes ___No
Any previous surgeries, serious injuries or diseases of the eye?____
How many hours a day do you spend reading, using a computer or other near work ?____________

What Hobbies or Activities are you involved in?____

Medical History

Primary Care Physician/Clinic: ____________________

Do you have allergies to any medications? ☐ NO ☐ YES: ____________________

List all medications you are currently taking (including birth control, aspirin, vitamins and eye drops):

____

____

Do you currently have any medical conditions in the following areas:

- ☐ General health (example: fever, unexplained weight gain/loss)
- ☐ Endocrine (diabetes, thyroid, other glands)
- ☐ Muscles/Joints (arthritis, myalgia)
- ☐ Skin (rash, itching, hair, breast)
- ☐ Ear/Nose/Throat (sinus, tinnitus, dry mouth)
- ☐ Heart/Vascular (high blood pressure, arrythmia, heart attack, stroke)
- ☐ Stomach/Digestive (heartburn, ulcer, IBS, Crohn's)
- ☐ Neurological (seizure, migraine, numbness)
- ☐ Psychiatric (mood, depression, attention, drug abuse)
- ☐ Allergy (seasonal, dander, food)
- ☐ Respiratory (asthma, cough, shortness of breath)
- ☐ Urinary/Genital (kidney, bladder, cysts, prostate)
- ☐ Blood (cholesterol, bruising, bleeding, anemia)
- ☐ Infectious disease (HIV, hepatitis, STD, tuberculosis)

Do you Smoke? ☐ NO ☐ YES: ________ cigarettes per day

Do you drink alcohol? ☐ NO ☐ YES: ________ drinks per week

Are you currently pregnant or breastfeeding? ☐ NO ☐ YES

Family History

To the best of your knowledge has anyone in your family been diagnosed with or treated for:

	Relationship:
☐ Glaucoma	
☐ Cataracts	
☐ Macular Degeneration	
☐ Lazy eye, Crossed eyes	
☐ Blindness	
☐ High blood pressure	
☐ Diabetes	
☐ Heart disease	
☐ Cancer	

For In-Office Use Only

☐ NO CHANGE ☐ CHANGE: ____________________ | Initial | Date

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☐ NO CHANGE ☐ CHANGE: ____________________ | Initial | Date