Patient Information

Date: _____

Last Name: _____ First Name: _____ MI: _____

Gender: ☐ Male ☐ Female Date of Birth: _____ Marital Status: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Work Phone: ( ) _____ Social Security #: _____

E-mail: _____

Employer: _____ Occupation:_____

Who Can We Thank for Your Referral: Walk-in / Insurance / Internet / Friend _____

Emergency Contact: _____ Phone #: _____

Insurance Information (*please bring all insurance cards to receptionist*)

Primary Medical Insurance: _____ Secondary: _____

Vision Insurance: _____

Authorizations *I have read and understand the following statements.*

I acknowledge that I have been given the opportunity to review and request a copy of Big Bend Family Eye Care's Notice of Privacy Practices (HIPAA). Big Bend Family Eye Care's Notice of Privacy Practices can be located in the lobby or you may request a copy from the Front Desk. If you have any questions regarding the information in Big Bend Family Eye Care's Notice of Privacy Practices, please do not hesitate to contact a clinic representative or the Big Bend Family Eye Care's Privacy Officer as indicated on your Notice.

Patient Signature: _____ Date: _____

I authorize the release of any medical information necessary to process insurance claims to my insurance company and/or any other physician or health care provider that may be involved in my care. I authorize and request my insurance company to remit payment of benefits directly to Big Bend Family Eye Care. I further understand that I am responsible for payment for all services rendered including those services that may not be covered by my insurance company. This authorization is to be valid until otherwise revoked in writing.

Patient Signature: _____ Date: _____

The doctors at Big Bend Family Eye Center routinely dilate the pupils of the eyes in order to obtain a thorough view of the interior structures of the eye. Without pupil dilation, the doctor will not be able to completely evaluate your eye health and may not detect certain diseases and disorders. Pupil dilation usually results in blurry near vision and increased light sensitivity for 3 to 6 hours. Although most patients have minimal effect upon their distance vision and feel comfortable driving after dilation, it is possible that you may not see well enough to drive safely. It is your responsibility to make arrangements to be transported by other means if you feel that your vision is too blurry to drive safely following dilation. It is also your responsibility to notify the doctor and staff if you do not wish to have your eyes dilated or would prefer to reschedule the dilation.

Patient Signature: _____ Date: _____

Patient Name: _____ When was your last eye exam? _____

What is the main reason for your visit today? _____

What questions or problems with your current glasses or contacts would you like to discuss with the doctor or staff today? _____

_____

How many pairs of prescription glasses do you currently have? ☐0 ☐1 ☐2 ☐more than 2

What sporting activities or hobbies are you involved with? _____

_____

Do you currently wear contacts? ☐Yes ☐No If no, are you interested in wearing them? _____

If you currently wear contacts, are you satisfied with your vision? _____ with the comfort? _____

Are you interested in Laser Vision Correction? ☐Yes ☐No

Primary Care Physician: _____ Pharmacy: _____

Name of all current medications (Rx and over the counter)

_____ _____

_____ _____

_____ _____

_____ _____

Any known drug allergies? _____

Personal & Family Medical History

	Self		Family			Self		Family	
Allergies	Yes	No	Yes	No	Migraines	Yes	No	Yes	No
Arthritis	Yes	No	Yes	No	Stroke	Yes	No	Yes	No
Asthma/ COPD	Yes	No	Yes	No	Thyroid Disease	Yes	No	Yes	No
Cancer	Yes	No	Yes	No	Autism	Yes	No	Yes	No
Diabetes	Yes	No	Yes	No	Cataracts	Yes	No	Yes	No
Cholesterol	Yes	No	Yes	No	Eye Injury	Yes	No	Yes	No
Heart Attack	Yes	No	Yes	No	Eye Surgery	Yes	No	Yes	No
Heart Disease	Yes	No	Yes	No	Glaucoma	Yes	No	Yes	No
High Blood Pressure	Yes	No	Yes	No	Macular Degeneration	Yes	No	Yes	No