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SOUTHERN UTAH EYE CARE

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Southern Utah's Premier Optical and Contact Lens Center

WELCOME TO OUR OFFICE

PLEASE TAKE A MOMENT TO FILL OUT OUR BRIEF PATIENT INFORMATION FORM

PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms. Name: _____ Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Birth Date: ____/____/____ Social Security #: ____/____/____ Home Phone: ( )____-____
E-mail _____ Cell Phone: ( )____-____
Employed by: _____ Occupation_____ Work Phone: ( )____-____
How did you hear about our office, or if referred, by whom? (Referrals from our loyal patients are always appreciated)
_____

INSURANCE AND BILLING INFORMATION

Guarantor or Head of Household: Name: _____ Relationship: _____
Billing Address: _____ City: _____ State: _____ Zip: _____
Members Date of Birth ____/____/____Primary Insurance: _____Secondary Insurance: _____

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize the release of medical information necessary for the payment of services and materials provided by Southern Utah Eyecare. I hereby authorize Southern Utah Eyecare to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits and I authorize payment of these benefits directly to Southern Utah Eyecare on my behalf for any services and materials furnished. **I understand that I am financially responsible, including all deductibles, for charges of Southern Utah Eyecare that are not paid by my insurance and/or Medicare. All medical care is due and payable upon completion unless prior arrangements have been specified. I acknowledge and agree that interest at the rate of 1 1/2 percent per month (18 percent per annum) will be charged on all balances remaining unpaid after said date of completion.** In the event of default and referral to an attorney or collection agency, I agree to pay all collection costs including reasonable attorney's fees.

Signature: _____ Date: _____

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES (HIPAA)

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Southern Utah EyeCare Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

_____ _____
Signature of Patient or Parent/Legal Guardian Date

Person(s) to Whom Information May Be Disclosed:

_____
_____
(Name of person(s) or organization)

SOCIAL HISTORY

This information is kept strictly confidential. You may discuss this portion directly with the doctor if you prefer.

☐ Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you use tobacco products? ☐ No ☐ Yes If yes, state type/amount/how long: _____
Do you drink alcohol? ☐ No ☐ Yes If yes, state type/amount/how long: _____
Do you use illegal drugs? ☐ No ☐ Yes If yes, state type/amount/how long: _____
Are you pregnant and/or nursing ☐ No ☐ Yes
Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Please turn over and complete the back side of this form. Thank you.

REVIEW OF GENERAL HEALTH

Do you currently have any health problems in the following areas? (circle all that apply)

CONSTITUTIONAL	Fever	Weight Loss / Gain	Fatigue	Other:_____
CARDIOVASCULAR	High Blood Pressure	Cholesterol	Heart Disease	Other:_____
EAR, NOSE, THROAT, MOUTH	Dry Throat / Mouth	Sinus Conditions	Hearing Problems	Other:_____
RESPIRATORY	Asthma	Shortness of Breath	Chronic Bronchitis	Other:_____
GASTROINTESTINAL	Nausea / Vomiting	Abdominal Pain	Loss of Appetite	Other:_____
GENITOURINARY	Kidney / Bladder	Prostate Problems	Hysterectomy	Other:_____
MUSCULOSKELETAL	Joint Pain / Stiffness	Arthritis	Back Pain	Other:_____
INTEGUMENTARY	Itchy skin or Rash	Eczema	Skin Cancer	Other:_____
NEUROLOGICAL	Light Headed or Dizzy	Seizures or Convulsions	Headache	Other:_____
PSYCHIATRIC	Depression	Anxiety	Confusion	Other:_____
ENDOCRINE	Thyroid / Other Glands	Diabetes Type I	Diabetes Type II	Other:_____
LYMPHATIC / HEMATOLOGIC	Anemia	Bleeding Disorders	Bruising	Other:_____
IMMUNOLOGIC / ALLERGIC	Allergies / Hay Fever	Immune System Disorders	Collagen/vascular	Other:_____

Name of your medical doctor(s)? _____

List any medications you are taking: _____

_____

Allergies to medications? ☐ No ☐ Yes Please list:_____

EYE HISTORY

Please note any current eye difficulties that you are experiencing:

- ☐ **GLAUCOMA**
- ☐ **CATARACTS** surgery? ☐ right eye ☐ left eye
- ☐ **MACULAR DEGENERATION** ☐ dry ☐ wet
- ☐ **EYE INJURY**
- ☐ **LOSS OF SIDE VISION**
- ☐ **DOUBLE VISION**
- ☐ **FLASHES OF LIGHT / FLOATERS**
- ☐ **LASIK / PRK**
- ☐ **EXCESS TEARING / WATERING**
- ☐ **DRYNESS**
- ☐ **SANDY OR GRITTY FEELING**
- ☐ **ITCHING**
- ☐ **BURNING**
- ☐ **FOREIGN BODY SENSATION**
- ☐ **GLARE / LIGHT SENSITIVITY**
- ☐ **DROOPING EYELIDS**

If you answered YES to any of the above or have a condition not listed, please explain:

_____

_____

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE	YES	NO	PERSON(S)
GLAUCOMA	☐	☐	_____
CATARACT	☐	☐	_____
MACULAR DEGENERATION	☐	☐	_____
RETINAL DETACHMENT / DISEASE	☐	☐	_____
CROSSED EYES (STRABISMUS))	☐	☐	_____
LAZY EYE (AMBLYOPIA))	☐	☐	_____
CANCER (Type:_____)	☐	☐	_____
DIABETES	☐	☐	_____
KERATOCONUS	☐	☐	_____
OTHER_____	☐	☐	_____