PATIENT INFORMATION

(Please Print)

Mr. Mrs. Ms. Miss Dr. **Date:_____**

Name:_____ **Preferred Name:_____**

Date of Birth:_____ **Male/Female** **Social Security #: XXX-XX-_____**

Address:_____
Street City State Zip

Phone: Home (_____)_____ **Cell (_____)_____** **Texting OK? Yes No**

Email:_____ **Work (_____)_____**

Employer:_____ **Occupation:_____**

Complete if patient is under 18 years old, or a student

Name of Father_____ **Employer_____**

Name of Mother_____ **Employer_____**

Address:_____ **Phone (_____)_____**

Insurance Information

Subscriber's Name_____ **Subscriber's Date of Birth___/_____/_____**

Patient's relation to Subscriber (please circle) Self Spouse Child Other_____

Subscriber's SS#/ID Number _____ Subscriber's Employer_____

Vision Insurance (please circle) VSP Eyemed Other_____

Medical Insurance (please circle) BCBS PPO Medicare Humana Aetna Other_____

If you are a member of the above Insurance plans, your insurance company will be billed directly for services less any applicable deductions (Co-pays, Co-insurance, etc.). Please provide your ID cards to the reception staff.

Financial Assignment and Agreement

1. **Please remember insurance is considered a method of reimbursing the patient for fees paid to the doctor and not a substitute for payment. It is the responsibility of the patient (or parent if a minor) to pay any deductible amount, co-insurance, or any balances not paid by your insurance.**
2. **Payment is expected at time of service, unless other arrangements have been made in advance. In cases of divorce, the parent/guardian present with the child will be responsible for payment.**
3. **In the event Johnson Eye Care is not a participating provider in your health plan you will be expected to pay for all services and materials received.**
4. **I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished and, I authorize any holder of medical information to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.**
5. **This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurances. I hereby authorize said assignee to release all information necessary to secure the payment.**

Privacy: I acknowledge that a copy of Johnson Eye Care's Notice of Privacy Practices was made available to me.

Signed_____ Print Name _____ ____/____/____
(Patient or Parent if Minor) **Date**

PLEASE COMPLETE SECOND PAGE

In compliance with Federal Guidelines, please fill out this form completely.

Patient's Name:_____ **Date:**_____

MEDICAL HISTORY

Do you have any allergies?	Y	N	Please list_____
Do you have any allergies to medications?	Y	N	Please list_____
Are you presently taking any medications?	Y	N	Please list_____
Are you pregnant or breastfeeding?	Y	N	_____
Do you use a computer?	Y	N	How many hours per day?_____
Have you ever worn: Contact Lenses?	Y	N	Glasses? Y N

REVIEW OF SYSTEMS

Please circle if you have any of the following conditions.

CONSTITUTIONAL		
Fever, Sudden weight loss/gain	Y	N
Cancer	Y	N
EARS, NOSE, MOUTH, THROAT		
Allergies/Hay Fever	Y	N
Sinus congestion	Y	N
Chronic Cough	Y	N
NEUROLOGICAL		
Multiple Sclerosis	Y	N
Headaches/Migraines	Y	N
Seizures	Y	N
VASCULAR/CARDIOVASCULAR		
High Blood Pressure	Y	N
High Cholesterol	Y	N
Other	Y	N
RESPIRATORY	Y	N
Asthma	Y	N
Chronic Bronchitis	Y	N
Emphysema	Y	N
GASTROINTESTINAL		
Diarrhea/Constipation	Y	N
GENITOURINARY		
Genitals/Kidney/Bladder	Y	N
PSYCHIATRIC	Y	N

BONES/JOINTS/MUSCLES		
Muscle/Joint Pain	Y	N
Rheumatoid Arthritis	Y	N
ENDOCRINE		
Diabetes	Y	N
Thyroid	Y	N
Other	Y	N
LYMPHATIC/HEMATOLOGIC		
Bleeding Problems	Y	N
Anemia	Y	N
INTEGUMENTARY		
Skin condition	Y	N
EYES		
Dryness	Y	N
Tearing/Watering	Y	N
Glare or light sensitivity	Y	N
Loss of Vision	Y	N
Double Vision	Y	N
Flashes/Floaters	Y	N
Distorted Vision/Halos	Y	N
Eye Surgeries/Lasik	Y	N
Please list _____		

Please list any other health problems_____

FAMILY HISTORY

Does anyone in your biological family have or been treated for: (parents, grandparents, siblings)

High Blood Pressure	No	Yes,who?_____	Retinal Detachment or Degeneration	No	Yes,who?_____
Thyroid Problems	No	Yes,who?_____	Glaucoma	No	Yes,who?_____
Diabetes	No	Yes,who?_____	Macular Degeneration	No	Yes,who?_____
Cancer	No	Yes,who?_____	Any other health problems?	No	Yes,who?_____

SOCIAL HISTORY (This information is kept strictly confidential)

Do you drink alcohol?	Y	N	How often?_____
Do you use tobacco products?	Y	N	How long/often?_____
Do you use illegal drugs?	Y	N	Type? _____
Have you ever been exposed to or infected with:	Y	N	Gonorrhea Hepatitis HIV Syphilis