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:____

<u>Complete if patient is under 18 years old, or a student</u>

Name of Father/Guardian__________________________ Name of Mother/Guardian______________________________

Address: ____ Address: ____

Phone: (________)________________________________ Phone: (________)_____________________________________

Insurance Information

Member's Name____ Member's Date of Birth______/______/______

Patient's relation to Member (please circle) Self Spouse Child Other____________________________

Member's SS#/ID Number ________________________________ Member'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.). <u>Please provide your ID cards to the reception staff</u>.

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/Guardian if Minor) Date

PLEASE COMPLETE SECOND PAGE

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

Patient's Name:____ **Date:**__________________

PATIENT 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______________________________________

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Have you ever worn contact lenses? Y N How many hours a day do you use the computer?________________

Have you ever worn glasses? Y N Are you pregnant/breastfeeding? Y N

REVIEW OF SYSTEMS

Please circle Yes or No to the following conditions.

CONSTITUTIONAL		
Fever, Sudden weight loss/gain	Y	N
Cancer__________________	Y	N
EARS, NOSE, MOUTH, THROAT		
Sinus congestion	Y	N
Allergies/Hay Fever	Y	N
Chronic Cough	Y	N
NEUROLOGICAL		
Multiple Sclerosis	Y	N
Headaches/Migraines	Y	N
Seizures	Y	N
VASCULAR/CARDIOVASCULAR		
High Blood Pressure		
High Cholesterol	Y	N
Other ____________________	Y	N
INTEGUMENTARY		
Skin condition_______________	Y	N
RESPIRATORY	Y	N
Asthma	Y	N
Chronic Bronchitis	Y	N
Emphysema / COPD	Y	N
GASTROINTESTINAL		
GERD	Y	N
GENITOURINARY		
Genitals/Kidney/Bladder	Y	N
PSYCHIATRIC		
Anxiety/Depression	Y	N
Other___________________	Y	N

BONES/JOINTS		
Joint Pain	Y	N
Rheumatoid Arthritis	Y	N
Osteoarthritis	Y	N
ENDOCRINE		
Diabetes	Y	N
Thyroid_________________	Y	N
LYMPHATIC/HEMATOLOGIC		
Bleeding Problems	Y	N
Anemia	Y	N
EYES		
Dryness	Y	N
Redness	Y	N
Itching	Y	N
Tearing/Watering	Y	N
Glare or Halos	Y	N
Light Sensitivity	Y	N
Flashes/Floaters	Y	N
Loss of Vision	Y	N
Double Vision	Y	N
Distorted Vision	Y	N
Macular Degeneration	Y	N
Glaucoma	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?_______________

Thyroid Problems No Yes,who?_______________

Diabetes No Yes,who?_______________

Cancer No Yes,who?_______________

Macular Degeneration No Yes,who?_______________

Glaucoma No Yes,who?_______________

Any other health problems? No Yes,who?________________

Please List____

SOCIAL HISTORY (This information is kept strictly confidential)

Do you drink alcohol? NONE Less than 1 Drink/Day 1-2 Drinks/Day

Do you use tobacco products? Y N Type/How often?_______________________________

Do you use illegal drugs? Y N Type/How often?_______________________________

Have you ever been exposed to or infected with: Y N Gonorrhea Hepatitis HIV Syphilis