Patient Information

Last Name_____ **First Name**_____ **MI**____ **Sex** M F **Date of Birth**_____

Preferred Name_____ **Preferred Phone**_____ ❑Cell Phone ❑Land Line

Address_____ **City**_____ **State**_____ **Zip**_____

Social Security Number_____**Email Address**_____

Occupation_____**What is the purpose of this visit?** _____

***New Patients Only*: Who may we thank for referring you to our office?**_____

If not referred, how did you choose our office? ❑Another Doctor ❑Insurance List ❑Saw Sign/Building ❑Newspaper/Radio/TV ❑Website ❑Google

Patient Medical History

Name of Family Physician_____**City**_____**Date of Last Check Up**_____

Current Medications (List names of all medications, eye drops, vitamins, supplements, birth control pills or ***you may provide a separate list***):

Prescription Medications:	**Vitamins/Supplements:**	**Over the Counter:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies to Medications(s)? ❑Yes ❑No If yes, what medication(s)_____

Have you had any eye surgeries? ❑Yes ❑No If yes, what procedure?_____

Do you use cigarettes/tobacco, alcohol or other substances? ❑Yes ❑No

Have you ever been diagnosed or treated for the following health problems?

❑Allergies	❑Arthritis	❑Blood/Lymph	❑Bronchitis	❑Cancer	❑Cardiovascular (Heart)	❑Cholesterol
❑Diabetes	❑Digestive	❑Endocrine	❑Ear/Nose/Throat	❑Eczema/Rashes	❑Fatigue	❑Fevers
❑Genitourinary	❑ Thyroid	❑Skin	❑Kidney	❑Muscle/Bone	❑Neurological	❑Psychological
❑Respiratory	❑Sinus	❑Throat Infections	❑High Blood Pressure		❑Unusual Weight Loss/Gain	

Patient Eye History – Have you experienced, been diagnosed or treated for the following health problems?

❑Blurry Vision	❑Cataracts	❑Dryness	❑Eye Infections	❑Tearing	❑Flash of Light	❑Glaucoma
❑Headaches	❑Itchiness	❑Burning	❑Lazy Eye	❑Uncomfortable Glasses	❑Double Vision	❑Eye Injury
❑Macular Degeneration	❑Floaters/Spots	❑Grittiness	❑Iritis/Uveitis	❑Retinal Detachment	❑Corneal Abrasions	
❑Crossed Eye/Eye Turn	❑Sunlight Sensitivity		❑Trouble Seeing at Night			

❑Other Eye Disorders_____

Date of Last Eye Exam?_____ **By Whom?**_____

Do you currently wear Prescription Glasses? ❑ Yes ❑ No **Do you wear Contact Lenses?** ❑ Yes ❑ No
If Contacts, what brand?_____

Any problems with your current prescription glasses or contact lenses?_____

Family Eye History – Is there a *family* medical history of any of the following?

	Relationship (Mother or Father's Side)		Relationship (Mother or Father's Side)
❑Blindness	_____	❑Glaucoma	_____
❑Cataracts	_____	❑Lazy Eye	_____
❑Corneal Problems	_____	❑Macular Degeneration	_____
❑Diabetes	_____	❑Retinal Problems	_____

Insurance Information

Vision Insurance Name_____

Subscriber Name_____

Subscriber SSN_____ **Subscriber D.O.B.**_____

Subscriber Employer_____

Primary Medical Insurance Name_____

Subscriber Name_____

Subscriber SSN_____ **Subscriber D.O.B.**_____

Subscriber Employer_____

Signature

- **Please be advised if you use insurance coverage for any visits to Aurora Eye Care, this is a contract between you and your insurance company, <u>not</u> Aurora Eye Care.**
- **If your insurance company has not reimbursed our office in full within 90 days, you are responsible for providing payment in full to Aurora Eye Care.**

How will you settle your account today? ❑Cash ❑Check ❑Credit/Debit Card

I have read and understand the Consent Form and consent to the use and disclosure of my health information for the purpose of treatment, payment, and health care operations.

_____ _____

Patient Signature (Parent or Guardian if Patient is a Minor) Date