Name:______________________________ Date:________________

Please fill this form out completely. Many systemic health issues and medications can affect your ocular health. We may utilize electronic healthcare databases to receive information about your medication and health history.

PATIENT HISTORY

All Current Medications and Dosage if known:____

____

____

Medication Allergies/Reaction:____

Environmental Allergies/Reaction:____

Date of last eye exam:_____________ Where?_________________________

Eye Surgeries ❑ Types/Approx Dates:____

Eye injuries ❑ Types/Approx Dates:____

Previous eye problems ❑ Please explain:____

Wear glasses? ❑ When were they last updated?_______________________________________

Wear contact lenses? ❑ Type:________________________Solution:_____________________________

If not a current contact lens wearer, are you interested in wearing contact lenses? Yes ❑ No ❑

Do you plan to order new glasses today? Yes ❑ No ❑ Only if necessary ❑

General Surgeries – list type/approximate date ____

____

Family doctor:____ Date of last visit:____________

Current smoker ❑ Former smoker ❑ Never a smoker ❑

FAMILY HISTORY ***Any relatives with these conditions? Check all that apply, indicate how related.***

❑ Macular Degeneration ___________

❑ Glaucoma ____________________

❑ Diabetes______________________

❑ Lazy Eye _______________________

❑ Retinal Detachment _______________

❑ Cataract __________________________

SOCIAL HISTORY

Occupation:_____________________Currently a Student(grade/school)________________________

Hobbies (sports, computers, reading, crafts/sewing, shooting sports, etc.)________________________

____

HEALTH HISTORY **(Please mark all that apply or None for each category.)**

Eyes
- ❑ Eye Strain
- ❑ Blur
- ❑ Double Vision
- ❑ Dryness
- ❑ Watering/Matter
- ❑ Pain/Discomfort
- ❑ Itching
- ❑ Redness
- ❑ Floaters
- ❑ Flashing lights
- ❑ Lazy Eye
- ❑ Light Sensitive
- ❑ **None apply**

Allergy/Immune
- ❑ Allergies
- ❑ Rheum Arthritis
- ❑ Lupus
- ❑ **None apply**

Cardiovascular
- ❑ Blood pressure
- ❑ Heart Disease
- ❑ Heart Attack
  Date:__________
- ❑ Stroke
  Date:__________
- ❑ High Cholesterol
- ❑ **None apply**

Respiratory
- ❑ Asthma
- ❑ Sleep Apnea
- ❑ COPD
- ❑ **None apply**

Musculoskeletal
- ❑ Fibromyalgia
- ❑ Osteoporosis
- ❑ Arthritis - Osteo
- ❑ **None apply**

Ear, Nose, Throat & Mouth
- ❑ Sinus
- ❑ Sjogrens
- ❑ Dizziness
- ❑ **None apply**

Endocrine
- ❑ Diabetic
  - ❑ Insulin
  - ❑ Oral/Diet
- ❑ Thyroid
- ❑ Hormone Replacement
- ❑ **None apply**

GI
- ❑ Crohn's
- ❑ Colitis
- ❑ Acid Reflux
- ❑ **None apply**

Hemat/Lymph
- ❑ Anemia
- ❑ Leukemia
- ❑ **None apply**

Skin/Integumentary
- ❑ Acne Rosacea
- ❑ Eczema
- ❑ Dermatitis
- ❑ **None apply**

Genitourinary
- ❑ Pregnant
- ❑ Breast Feeding
- ❑ HIV
- ❑ Kidney Stones
- ❑ Hepatitis
  Type:_____
- ❑ **None apply**

Neurological
- ❑ Headache
- ❑ MS
- ❑ Epilepsy
- ❑ **None apply**

Psychiatric
- ❑ Anxiety/Panic
- ❑ Depression
- ❑ ADHD
- ❑ Bipolar
- ❑ **None apply**

Constitutional
- ❑ Devel disablity
- ❑ Weight loss
- ❑ Fatigue
- ❑ Cancer
  Type:___________
- ❑ **None apply**

Note any other systemic health conditions not indicated above:____________________________________

____

Who may we thank for referring you to our office?________________________

I acknowledge receipt of a copy of the Tipp Eye Center Notice of Privacy Practices:

Signature:____Date:___________________

Please complete the following information. Provide our receptionist with your medical and vision plan cards. Please send these cards with unaccompanied children for their exam.

Name:____________________________ Preferred Nickname:_________________________________

Address:____
Street City State Zip

I prefer to be contacted by Home Phone ❑ Cell Phone ❑ Work Phone ❑ (May we call you at work Y N?)

Numbers: Home: ____________________ Cell :_________________________ Work:________________

Email: ___________________ (This will allow you to access an electronic summary of your examination)

Date of Birth:____________________________ Social Security Number:____________________________

Insurance Company Names: Medical __________________________ Vision:_________________________

Emergency Contact/Phone:____________________________________Relationship:________________

PERSON RESPONSIBLE FOR PAYMENT/ INSURED, IF NOT SELF

Please understand that financial responsibility for your account is yours, not your insurance company's.

Name:______________________________ Relationship to patient (i.e. parent, spouse, etc.)________________

Street Address, if different than above:____
Street City State Zip

Phone, if different from above:_______________Social Security # _______________ Date of Birth:_________

Employer:_____________________ Work Phone:_________________ May we contact you at work? Y N

Payment in full is expected at the time of service by cash, check, Visa or MasterCard. We will gladly assist you in providing information to help expedite insurance carrier payments in order for you to be reimbursed.

SIGNATURE ON FILE: I request that payment of authorized medicare or other insurance be made to Tipp Eye Center, Inc. I authorize the release of medical or other information necessary to process insurance claims on my behalf. I understand that my medical records are confidential. I understand that by signing this consent form I am allowing my medical information to be released upon my insurance company's request, to my insurance company for the purpose of Health Care Operations (including, but not limited to, provider review functions, claims payment and quality assessment). I also understand that I may revoke this consent by written request, at any time, with this doctor. If revoked, it is understood by all parties that all information released prior to being notified of such revocation was made with my consent. Additionally, I understand that if I revoke this release of information, my insurance can not pay my claims without the information requested.

Signature:____ Date:___________________OVER PLEASE ➔

PLEASE TURN OFF CELL PHONES WHILE IN THE OFFICE. THANK YOU.