I acknowledge that I received (or declined) a copy of the Tipp Eye Center Notice of Privacy Practices (you may request a copy upon your arrival at our office).

Signature:_____ Date:_____

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

Name_____Preferred Nickname_____

Address_____

Date of Birth:_____ Social Security Number:_____

City_____ State_____ Zip_____

I **prefer** to be contacted by Home Phone ☐ Cell Phone ☐ Work Phone ☐ (May we call you at work? ☐Yes ☐No)

Numbers: Home:_____ Cell:_____ Work:_____

Email:_____

Insurance Company Names: Medical_____Vision:_____

Emergency Contact Name/Phone:_____ Relationship:_____

Primary Language: ☐ English ☐ Other

Race: ☐White ☐ Black/African-American ☐ Hispanic ☐ Asian ☐ American Indian or Alaska Native ☐ Other

Ethnicity: ☐ Non-Hispanic/Latino ☐ Hispanic/Latino

INSURANCE POLICY HOLDER / INSURED IF NOT SELF

Name:_____Relationship to patient (i.e. parent, spouse, etc.)_____

Street Address (if different than above)_____

City_____ State_____ Zip_____

Phone(if different from above):_____Social Security #_____

Date of Birth:_____

Employer:_____Work Phone:_____

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

Payment in full is expected at the time of service payable by cash, check, Visa, MasterCard, Discover or Care Credit. We will also 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 cannot pay my claims without the information requested.

Signature:_____Date:_____

PLEASE COMPLETE OTHER SIDE OF FORM AS WELL

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

Name:_____ Date:_____

PLEASE FILL THIS FORM OUT COMPLETELY! Many systemic health issues and medications can affect your eye health. We may utilize electronic healthcare databases to retrieve information about your medications and health history.

PATIENT OCULAR HISTORY

Date of last eye exam:_____ Where?_____
Have you ever been diagnosed with any eye problems or eye diseases **besides** needing glasses? ☐ **Yes** ☐ **No**
If yes, please explain:_____
Eye Surgeries **Yes** ☐ **No** ☐ Types/Approx Dates:_____
Eye injuries **Yes** ☐ **No** ☐ Types/Approx Dates:_____
Wear glasses? **Yes** ☐ **No** ☐ When were they last updated?_____
Wear contact lenses? **Yes** ☐ **No** ☐ 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** ☐

PATIENT HEALTH HISTORY (Please mark all that apply or "None Apply" 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
☐ None apply

Ear, Nose, & Throat
☐ Sinus
☐ Sjogrens
☐ Dizziness
☐ None apply

Endocrine
☐ Diabetic: Type I ☐ II ☐
Insulin ☐
Oral/Diet ☐
☐ Thyroid
☐ Hormone Therapy
☐ 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
☐ Seizure Disorder
☐ None apply

Psychiatric
☐ Anxiety/Panic
☐ Depression
☐ ADHD
☐ Bipolar
☐ None apply

Constitutional
☐ Devel disability
☐ Weight loss
☐ Fatigue
☐ None apply

Have you ever had any type of cancer? **Yes** ☐ **No** ☐ If so, when?_____
Type?_____ Treatment:_____

Note any other systemic health conditions not indicated above:_____

Family doctor:_____ Date of last visit:_____
All Current Medications and Dosages if known:_____

Medication Allergies/Reaction:_____
Environmental Allergies/Reaction:_____
Current Smoker ☐ Former Smoker ☐ Never a Smoker ☐

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

☐ Glaucoma_____
☐ Macular Degeneration_____
☐ Lazy Eye_____
☐ Cataracts_____
☐ Diabetes_____
☐ Retinal Detachment_____
☐ Cancer_____
☐ Heart Problems_____

SOCIAL HISTORY

Occupation:_____ Currently a Student(grade/school)_____
Hobbies (sports, computers, reading, crafts/sewing, shooting sports, etc.)_____