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.

Full Name_____ M.I._____ Preferred Nickname_____

Date of Birth_____ Social Security Number_____

Address_____

City_____ State_____ Zip Code_____

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

Numbers: Home_____ Work_____ Cell_____

Email (will be your login for our portal)_____

Insurance Company Names: Medical_____ Vision_____

Emergency Contact Name_____ Phone_____ Relationship_____

Primary Language: ☐ English ☐ Other_____

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

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

INSURANCE POLICY HOLDER / INSURED IF NOT SELF

Full Name_____ Relationship to patient (i.e. parent, spouse, etc.)_____

Street Address (if different than above)_____

City_____ State_____ Zip Code_____

Phone (if different from above)_____ Social Security Number_____

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, American Express 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 SILENCE CELL PHONES WHILE IN THE OFFICE. THANK YOU.

Name_____ Date_____

PLEASE FILL THIS FORM OUT COMPLETELY 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)

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
☐ Sjogren's Syndrome
☐ Lupus
☐ HIV

☐ Hepatitis: Type___
☐ None Apply

Cardiovascular
☐ High Blood Pressure
☐ Heart Disease
☐ Heart Attack: Date_____
☐ Stroke: Date_____
☐ High Cholesterol
☐ None Apply

Respiratory
☐ Asthma
☐ Sleep Apnea
☐ COPD
☐ None Apply

Musculoskeletal
☐ Fibromyalgia
☐ Osteoporosis
☐ Arthritis

☐ Gout
☐ None Apply

Ear, Nose & Throat
☐ Sinus
☐ Dizziness
☐ Hearing Loss
☐ None Apply

Endocrine
☐ Diabetic:
Type I ☐ Type II ☐
Insulin ☐ Oral/Diet ☐
☐ Thyroid
☐ Hormone Therapy
☐ None Apply

GI
☐ Crohn's
☐ Colitis
☐ Acid Reflux

☐ Celiac Disease
☐ None Apply

Hemat/Lymph
☐ Anemia
☐ Leukemia
☐ None Apply

Skin/Integumentary
☐ Acne Rosacea
☐ Eczema
☐ Dermatitis
☐ Psoriasis
☐ Hx of Shingles
☐ None Apply

Genitourinary
☐ Pregnant: Due_____
☐ Breast Feeding
☐ Kidney Disease
☐ Kidney Stones

☐ Prostate Disease
☐ BPH
☐ None Apply

Neurological
☐ Headache
☐ Migraine
☐ MS
☐ Seizure Disorder
☐ Cerebral Palsy
☐ None Apply

Constitutional
☐ Devel Disability
☐ Autism Spectrum
☐ Attention Deficit
☐ Fatigue
☐ None Apply

History of Cancer? ☐ Yes ☐ No Type_____ Treatment_____ When_____
Family Doctor_____ Specialists_____
List All Current Medications _____

_____

_____

_____

_____

Medication Allergies/Reactions_____
Environmental Allergies/Reactions_____
Current Smoker ☐ Former Smoker ☐ Never Smoker ☐

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

☐ Glaucoma_____
☐ Macular Degeneration_____
☐ Lazy Eye_____

SOCIAL HISTORY

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

_____

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). I also acknowledge that my current spectacle and contact lens prescriptions are available to me digitally via the Tipp Eye Center HIPAA compliant, secure patient portal at https://www.revolutionphr.com/

Signature_____ Date_____