PATIENT INFORMATION FORM

LINSEY EYECARE

PRINT CLEARLY

Thank you for choosing our office for your eyecare needs. The information provided below will remain confidential with our office. We are happy to help you if you would need any assistance completing this form in its entirety.

Legal Name (First, MI, Last) | Nickname

Date of Birth | Age | Social Security Number

Address | City | State | ZIP

☐ Home ☐ Cell

Primary Phone

☐ Home ☐ Cell

Secondary Phone

Sex: ☐ Male ☐ Female **Status:** ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse's Name | Phone

Employment: ☐ Employed Full-time ☐ Employed Part-time ☐ Student ☐ Retired

Employer / School Name | Occupation | Phone

Address | City | State | ZIP

EMERGENCY CONTACT:

Name | Phone

Address | City | State | ZIP

PHYSICIAN INFORMATION:

Primary Care Physician / Pediatrician Name | Practice or Group Name

Address | City | State | ZIP | Phone

INSURANCE/BILLING

LINSEY EYECARE

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Please complete all applicable sections, sign the appropriate method of payment, and bring insurance cards to your appointment.

PERSON RESPONSIBLE FOR PAYMENT: (required for minors)

Name (Last, First) | Phone

Address | City | State | ZIP

SELF-PAY: I understand payment is my responsibility due to no insurance coverage or other reasons.

Signature | Date

PRIMARY INSURANCE:

Insurance Name | ID# | Group#

Subscriber Name | Subscriber Date of Birth

Subscriber Social Security Number | Patient Subscriber Relationship

SECONDARY INSURANCE:

Insurance Name | ID# | Group#

Subscriber Name | Subscriber Date of Birth

Subscriber Social Security Number | Patient Subscriber Relationship

I authorize Linsey Eyecare to release any information in the course of my examination of treatment and permit payment directly to him or her, any benefits due for this service. I recognize and accept personal responsibility for any balance or fee not covered. If the insurance company pays me directly for services rendered, I will immediately forward that payment to Linsey Eyecare.

Signature | Date

MEDICARE:

I certify that the information given by me in applying for payment under TITLE XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment for me.

Signature | Date

LINSEY EYECARE

EYE HEALTH HISTORY

PRINT CLEARLY

Previous Eye Doctor _____ Date of Last Eye Exam _____

Do you wear glasses? ☐ Yes, how often _____ ☐ No

Do you wear contacts? ☐ Yes, hours/day and type _____ ☐ No

Have you had any eye surgery, laser treatment to the eye or eye injury? ☐ Yes ☐ No

If yes, please explain:

_____

_____

_____

What eye medications are you using at present?

Please give name(s) and dosage and how often taken, include eyedrops.

_____

_____

_____

_____

Check all specific eye problems or visual difficulties that you are experiencing now:

- ☐ Overall decline in vision
- ☐ Glare, sensitivity to light
- ☐ Poor night vision
- ☐ Loss of depth perception
- ☐ Double vision
- ☐ Floaters
- ☐ Halos
- ☐ Difficulty driving in the day or at night
- ☐ Difficulty reading traffic signs and/or judging distance
- ☐ Difficulty reading labels, price tags, small numbers
- ☐ Difficulty with fine handwork like golf, bingo, computer work, playing cards
- ☐ Difficulty walking, stooping, changing positions, using stairs
- ☐ Dry/gritty/burning eyes
- ☐ Crusts or mucus on eyes or lids
- ☐ Over-react to smoke, dust or light
- ☐ Eyes feel scratchy or sandy
- ☐ Eyes tear and water excessively
- ☐ Eyes feel painful or irritated

Do you or any blood relative have now or have had any of the following:

You	Relative	
☐	☐	Blindness
☐	☐	Cataracts
☐	☐	Corneal Problems
☐	☐	Glaucoma
☐	☐	Diabetic Retinopathy
☐	☐	Lazy Eye/Turned Eyes
☐	☐	Macular Degeneration
☐	☐	Poor Color Vision
☐	☐	Retinal Disease

MEDICAL HISTORY

LINSEY EYECARE

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Do you have now or have had any of the following:

- ☐ General - Fever, weight loss, weight gain
- ☐ Ear/Nose/Throat - Sinus congestion, runny nose, post-nasal drip, dry mouth
- ☐ Heart - Chest pains, palpitations, heart disease
- ☐ Lungs - Shortness of breath, cough, emphysema, asthma, Tuberculosis
- ☐ Gastrointestinal - Reflux, nausea, vomiting
- ☐ Genitourinary - Kidney stones, bladder problems, dialysis, kidney disease
- ☐ Hematologic/Lymphatic - Bleeding, bruising, swollen lymph nodes
- ☐ Musculoskeletal - Joint pain, arthritis, muscle weakness, back pain
- ☐ Neurological - Dizziness, headache, memory loss, migraines, seizures, Parkinson's Disease
- ☐ Psychiatric - Anxiety, depression
- ☐ Allergies - Seasonal, environmental, drugs, foods
- ☐ HIV/AIDS
- ☐ Drug Sensitivity
- ☐ Chemical Dependency
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Diabetes (TYPE:_____)
- ☐ Cancer
- ☐ Stroke (DATE:_____)
- ☐ Thyroid
- ☐ Multiple Sclerosis
- ☐ Hepatitis
- ☐ Other: _____

Are you allergic to any medicines, foods, or iodine?
If yes, please list:

_____

_____

_____

Are you pregnant or nursing? _____ **Smoke?** _____ **Use alcohol?** _____

Please list all medications and vitamins you are currently taking.
Give name(s) and dosage.

_____

_____

_____

Hobbies: _____

_____

_____

OFFICE POLICY / HIPAA

LINSEY EYECARE

PRINT CLEARLY

What is the primary purpose of your visit today? ☐ Routine Eye Exam ☐ Medical Problem

How did you hear about us? ☐ TV ☐ Newspaper ☐ Yellow Pages ☐ Internet ☐ Other

Do you have other family members who are patients here?

☐ Yes Name & Relationship _____ ☐ No

Have you visited our website, www.linseyeyecare.com? ☐ Yes ☐ No

What was the deciding factor in choosing Linsey Eyecare? (check all that apply)

☐ Name Recognition ☐ Physician Experience ☐ Location ☐ Insurance Participation ☐ Website

☐ Recommendation of Friend/Existing Patient ☐ Recommendation of Physician ☐ Other

Office Policy

We accept payment by Cash, personal check (with valid ID), Money Order, VISA, or MasterCard. There is a $25 charge on all returned checks. Payment in full is expected at the time services are rendered.

Insurance Policy

If you have insurance coverage, we will gladly file your claim for you if we participate with that insurance. For patients with appointments, we will verify benefits prior to your appointment. You will be expected to pay your estimated portion based on this verification at the time of service. Verification of benefits is only an estimate of coverage and is not a guarantee of coverage. If your insurance cannot be verified, you will be given the option of paying in full or rescheduling your appointment. You are responsible for all charges, regardless of insurance coverage. If your claim is denied by your insurance, you will be billed for payment. It is your responsibility to know your insurance policy and be aware of your benefits.

INITIAL HERE THAT YOU HAVE READ THE ABOVE OFFICE POLICIES: ✗ _____

HIPAA

By signing below, you are acknowledging that you were informed of our Notice of Privacy Practices and of your right to receive a copy of it.

✗ _____

Signature of Patient or Legal Representative Date

For Office Use Only

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date _____ Initials _____

Reason _____