



# Welcome To Coweta Eye Care

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you.

## PATIENT INFORMATION

Date \_\_\_\_\_

Patient \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Single  Married  Widowed  Separated  Divorced

Patient SS# \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Best email Address for you \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Occupation \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Primary Insurance Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

## INSURANCE

Primary Insured's Name \_\_\_\_\_

D.O.B. \_\_\_\_\_ Employer \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

ID # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Insured's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

ID # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to Sean Carr, O.D. all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature \_\_\_\_\_

Relationship \_\_\_\_\_

Date \_\_\_\_\_

## PHONE NUMBERS

Home \_\_\_\_\_ Work \_\_\_\_\_ Ext \_\_\_\_\_ Spouse's Work \_\_\_\_\_

Best time and place to reach you \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT** (Specify someone who does not live in your household.)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

## EYE HEALTH HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Date of last eye exam _____	Bloodshot Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No	Floaters or Spots <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of doctor _____	Blurred Vision—Distance <input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wear glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No	Burred Vision—Near <input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> All the time <input type="checkbox"/> Occasionally	Burning Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No	Itching Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Reading <input type="checkbox"/> Driving <input type="checkbox"/> TV	Cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No	Light Sensitive <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wear contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No	Color Vision—Poor <input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of Vision <input type="checkbox"/> Yes <input type="checkbox"/> No
Type _____ Hours/Day _____	Crossed Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No
Describe any problems you have with your contacts _____	Discharge from Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No	Night Vision—Poor <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Dizzy Spells <input type="checkbox"/> Yes <input type="checkbox"/> No	Red Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Double Vision <input type="checkbox"/> Yes <input type="checkbox"/> No	Seeing Halos <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you interested in contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dry Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No	Seeing Flashes <input type="checkbox"/> Yes <input type="checkbox"/> No
	Eye Infection <input type="checkbox"/> Yes <input type="checkbox"/> No	Temporary Loss of Vision <input type="checkbox"/> Yes <input type="checkbox"/> No
	Eye Injury <input type="checkbox"/> Yes <input type="checkbox"/> No	Twitching Eyelid <input type="checkbox"/> Yes <input type="checkbox"/> No
	Eye Strain <input type="checkbox"/> Yes <input type="checkbox"/> No	Vision Poor <input type="checkbox"/> Yes <input type="checkbox"/> No
	Fainting Spells, Blackouts <input type="checkbox"/> Yes <input type="checkbox"/> No	Watering Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No

## HEALTH HISTORY

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following/ Also place a mark to indicate if a blood relative has had any of the following problems.

	<b>Yourself</b>	<b>Family Members</b>		<b>Yourself</b>	<b>Family Members</b>
AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis (Type_____)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Acne/Rosacea	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lazy Eye	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blindness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Poor Color Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Retinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Sensitivity	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Turned Eye	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you pregnant? _____	Number of children _____	
Heart Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tobacco use _____	Alcohol use _____	

### MEDICATIONS

List medications you are currently taking, including eye drops:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Phone \_\_\_\_\_

### ALLERGIES

List your allergies to medications or other substances:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Sean Carr, O.D. for any services furnished me by that doctor. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agreed to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

\_\_\_\_\_  
Signature of Beneficiary

\_\_\_\_\_  
Date