Name_____ Date _____
First Middle Last

Street _____ City_____ State _____ Zip _____

Date of Birth _____Primary Phone _____ Secondary Phone _____

Social Security # _____ Parent's Name (for Children) _____ Marital Status: Single / Married / Other

Where Employed? (or grade in school)_____ Job Description_____

Family Doctor _____ Doctor's Phone_____

PLEASE REVIEW THE FOLLOWING STATEMENT:

The doctor sometimes recommends certain diagnostic tests, i.e. visual field. There is a fee for each of these tests. You are responsible for any fees that are not covered by your insurance benefits. You will be notified in advance of any recommended tests before they are performed.

INSURANCE INFORMATION

VISION INSURANCE_____

Policy # _____ Insured Name _____

Insured SSN # _____ Birth Date of Insured_____

Group or Policy # _____

MEDICAL INSURANCE _____

Group or Policy # _____

Family Doctor _____ Doctor's Phone _____

.

INSURANCE SIGNATURE ON FILE

I request that payment of authorized Medicare benefits or OTHER insurance be made either to or on my behalf to Lebanon Eyecare Associates for any services furnished. 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.

Lifetime Signature _____Date _____

NON-COVERED SERVICE (MEDICARE ONLY)

Medicare does not pay for the refractive part of any eye exam. If a refraction (part of the exam that determines your need for glasses) is necessary during the exam Medicare will disallow it, stating it is not a covered Medicare benefit. Therefore, the patient will be responsible for the charge.

Lifetime Signature _____ Date _____

HIPPA-PRIVACY POLICY

I acknowledge that I received a copy of Lebanon Eyecare Associates and their doctor's Notice of Privacy Practices.

Lifetime Signature _____ Date _____

Name_____ Date _____

REVIEW OF SYSTEMS

Do you currently or have you recently had any of the following problems:	Yes	No	If YES, please explain:
Chronic fever, unexpected weight loss/gain, fatigue, night sweats?			
Ear/nose/throat problems (e.g. hearing loss, sinus problems, sore throat)?			
Heart problems (e.g. chest pain, irregular heart beat)?			
Respiratory problems (e.g. shortness of breath, wheezing, coughing)?			
Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea)?			
Urinary problems (e.g. pain or discomfort, blood in urine)?			
Skin problems (e.g. rashes, excessive dryness)?			
Musculoskeletal problems (e.g. muscle aches, joint pain, swollen joints)?			
Neurologic problems (e.g. numbness, weakness, headaches, paralysis)?			
Psychiatric problems (e.g. depression, anxiety, sleep disorders)?			
Endocrine Problems (e.g. thyroid, diabetes, etc.)?			
Hematologic/Lymphatic (e.g. anemia, leukemia, etc.)?			

FAMILY AND SOCIAL HISTORY

Do any medical or eye diseases run in your family (e.g. diabetes, high blood pressure, cancer, glaucoma, macular degeneration)?

_____Yes _____No If YES, please explain:_____

_____

Do you smoke? _____If yes, how much? _____ Drink alcohol? _____ If yes, how much?_____

If employed, how many hours per week do you work?_____ Hobbies/Interests_____

MEDICAL STATUS

1. Have you ever been treated for any medical conditions (e.g. diabetes, high blood pressure, arthritis, etc.)?

_____Yes _____No If YES, please explain:_____

2. Have you ever had any eye disease (e.g. glaucoma, cataract, wandering or "lazy" eye, retinal detachment)?

_____Yes _____No If YES, please explain:_____

3. Have you ever had surgery?

_____Yes _____No If YES, please explain:_____

4. Have you ever been hospitalized?

_____Yes _____No If YES, please explain:_____

5. Do you take any medication?

_____Yes _____No If YES, please explain:_____

Do you take any eye medication?

_____Yes _____No If YES, please explain:_____

6. Do you have any drug or food allergies?

_____Yes _____No If YES, please explain:_____