*Professional Service ~ Personal Care*

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Name: ______________________________ Male / Female Date: ____________

Address: ______________________________ PO Box: __________ Home phone: ________

City/State/Zip: ________________________________________ Cell phone: __________

Birth Date ____________ SSN: ____________________ Work Phone: ____________________

E-mail address: ______________________________ Employer: ______________________________

Race: ___ Am. Indian ___ Asian ___ African American ___ Hispanic ___ White ___ Other

___ Single ___ Married ___ Child (Name of Parent/Guardian): ______________________________

Spouse: ________________ Birth Date: __________ Employer: ______________________________

Emergency Contact: ______________________________ Phone: ______________________________

Name of Medical Doctor: ______________________ Pharmacy: ______________________________

Do you have any allergies to medication? ___ No ___ Yes If yes, please list medicine:

______________________________________________________________________________

How do you plan to pay for your visit? (circle one) 1 – Cash · Check · Credit/Debit Card · HSA card

2 – Vision insurance (VSP/Spectera/Eyemed/Superior) 3 – "Wellness" or "Routine" billed to health ins.

4 – Health insurance (Medicare/BCBS/United, etc.) 5 – Employer · Work Comp · Accident insurance

6 – Assistance programs (Medicaid / Hawk-i) 7 – Other ______________________________

It is therefore clinic policy that payment is due for professional services. A deposit of 50% is required for materials ordered and full balance is due when dispensed. A 1.5% monthly late fee will be applied to unpaid balances after 60 days from date of invoice. Medicare, Medicare supplements, Medicaid, and other insurance claims are submitted by our office as a courtesy to our patients. Thank you for allowing the Eyecare Centre to provide care for your vision and eye health. If you have read and understand the payment policy, please sign:

X ______________________________________________________________ Date: ____________

**Approximate Blood Pressure:** ________/________ **Height:** ___________ **Weight:** _____________

***Do you have any of the following eye conditions?*** *(circle any conditions you have)*

Cataracts · Macular Degeneration · Glaucoma · Diabetic Retinopathy · Dry Eyes · Eye Infections or Allergies · Floaters/Flashes · Iritis/Uveitis · Retinal Defects
Redness · Burning · Itching · Tearing · Discharge
Blurred Vision · Eyestrain · Eye Pain · Sensitivity to lights · Headache · Poor Night Vision · Glare · Double Vision

***If you are currently taking any medications, circle what you are taking them for:***

| | |
|---|---|
| **Constitution:** | Developmental Disabilities · Cancer · Fatigue Syndrome |
| **ENT: / Neuro:** | Hearing Loss · Sinusitis · Dry Mouth / MS · Epilepsy · CP · Stroke · Migraine · Autism |
| **Psych:** | Depression · ADD · Anxiety · Bipolar |
| **Cardiovascular:** | High Blood Pressure · Stroke · Heart Disease · Vascular Disease · Congestive Heart |
| **Respiratory:** | Cigarette Smoker · Asthma · Bronchitis · Emphysemas · COPD · Sleep Apnea |
| **Gastrointestinal:** | Crohn's · Colitis · Ulcer · Acid Reflux · Celiac Disease |
| **Genitourinary:** | Kidney disease · Prostate disease/cancer · STD (Herpetic/Chlamydia) · Benign Prostate Hypertrophy · Pregnant · Nursing |
| **Musculoskeletal:** | Arthritis · Osteoarthritis · Fibromyalgia · Muscular Dystrophy · Ankylosing Spondylitis · Osteoporosis · Gout |
| **Integumentary:** | Eczema · Rosacea · Psoriasis · Herpes Simplex/Cold sores · Herpes Zoster/Shingles |
| **Endocrine:** | Type 2 Diabetes · Type 1 Diabetes · Thyroid Dysfunction · Hormonal Dysfunction |
| **Hema / Lymphatic:** | Anemia · Large volume blood loss · Ulcer · High Cholesterol |
| **Allergic / Immune:** | Drug Allergies · Environmental Allergies · Rheumatoid Arthritis · Lupus · Sjögren's |

**-----PLEASE LIST ALL MEDICATIONS YOU TAKE ON THE BACK OF THIS PAGE OR INCLUDE A LIST AT THE TIME OF YOUR VISIT----**

**Family Medical History:** ***(circle which family member has the following conditions)***

| | | | | | | |
|---|---|---|---|---|---|---|
| Cancer: | Father | Mother | Brother | Sister | Son | Daughter |
| Diabetes: | Father | Mother | Brother | Sister | Son | Daughter |
| High Blood Pressure: | Father | Mother | Brother | Sister | Son | Daughter |
| Hyperthyroidism: | Father | Mother | Brother | Sister | Son | Daughter |
| Hypothyroidism: | Father | Mother | Brother | Sister | Son | Daughter |
| Macular Degeneration: | Father | Mother | Brother | Sister | Son | Daughter |
| Glaucoma: | Father | Mother | Brother | Sister | Son | Daughter |
| Cataracts: | Father | Mother | Brother | Sister | Son | Daughter |

**Smoking Status:** Current · Former · Never **Drinking Status:** Social · Former · Never