

Welcome

The benefits of happy, healthy eyes are immeasurable! Our goal is to help you reach and maintain maximum ocular health. Please fill out this form completely. The better we communicate, the better we care for you.

Last Name: _____ First Name: _____ I prefer to be called: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Referred By: _____
SS#: _____ Date of Birth: _____ E-mail: _____
Occupation: _____ Employer: _____
Emergency Contact: _____ Phone #: _____ Last Eye Exam: _____
Single Married Divorced Separated Widowed Today's Date: _____

PERSONAL MEDICAL HISTORY

Allergic / Immune N Y _____
Blood / Lymph N Y _____
Cardiovascular N Y _____
Ear / Nose / Throat N Y _____
Endocrine (diabetes) N Y _____
Eyes N Y _____
Gastrointestinal N Y _____
Genital /Urinary N Y _____
Mental N Y _____
Nervous N Y _____
Respiratory N Y _____
Skin N Y _____

Do you have medication allergies? _____

Current Medication(s) _____

Have you had any operations? _____

Name of Family Doctor: _____

PERSONAL OCULAR HISTORY

Main Reason For Visit Today: _____

Blurred vision N Y _____
Burning N Y _____
Double vision N Y _____
Dryness N Y _____
Eye pain / Soreness N Y _____
Flashes / Floating N Y _____
Itching N Y _____
Mucous Discharge N Y _____
Redness N Y _____
Watering N Y _____

Do you wear contacts? N Y Type: _____

Are you interested in contacts? N Y

Are you interested in laser eye surgery? N Y

Have you had any eye operations? N Y

Name of Previous Eye Doctor: _____

FAMILY HISTORY INFORMATION

Cataracts N Y _____ Heart Disease N Y _____ Macular Degeneration N Y _____
Diabetes N Y _____ High Blood Pressure N Y _____ Poor Color Vision N Y _____
Glaucoma N Y _____ Lazy / Crosses Eye N Y _____ Retinal Disorder(s) N Y _____
Other eye condition(s) N Y Type: _____

INSURANCE INFORMATION

Circle type of Vision Insurance:

Vision Service Plan
Coordinated Vision Care
Vision Benefits of America
Medicare

Insured's ID#: _____ Relation: _____ Insured's Birth date: _____

For all other insurance plans, payment (cash/check/VISA/MC/Discover) is due IN FULL at the time of service. We are not required to bill your insurance carrier for you. We will happily provide you copies of your fees or assist you in any way possible. Please remember that most insurance plans do not cover your fees in full. You will be responsible for any deductibles, co-payments, or non-covered items at the time of service.

RELEASE: I authorize SouthWest Eyecare to release any information required for insurance processing. I understand that I am responsible for all charges and fees that my insurance company does not pay.

Patient signature (parent if minor): _____ Date: _____

THANK YOU !