

Dr. Angela Howell

EyeCare Registration and History Form

Patient Information

Date: _____
Patient: _____
Address: _____
City: _____
State: _____ Zip: _____
Sex: M F Age: _____ DOB: _____
Single Married Widowed
Sparated Divorced
Patient SS#: _____
Occupation: _____
Employer: _____
Employer Address: _____
Employer Phone: _____
Spouse's Name: _____
DOB: _____ SS#: _____
Occupation: _____
Spouse's Employer: _____
Who may we thank for referring you?

Insurance

Who is responsible for this account?

Relationship to Patient: _____
Insurance Co.: _____
Group #: _____
Is patient covered by additional insurance? Yes No
Subscriber Name: _____
DOB: _____ SS#: _____
Relationship to Patient: _____
Insurance Co.: _____
Group #: _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assigned directly to Dr. _____ all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the docotr to release all information necessary to secre 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

Name: _____ Relationship: _____
Home Phone: _____ Work Phone: _____

Eye Health History

Physician's Name: _____

Date of last visit: _____

Date of last eye exam: _____

Name of doctor: _____

Do you wear glasses: Yes No

 All the time Occasionally Reading

 Driving During TV

Do you wear contacts: Yes No

Type: _____ Hours/Day: _____

Discribe any problems you have with your contacts:

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

Bloodshot Eyes	Yes	No	Floaters or Spots	Yes	No
Blurred Vision- Distance	Yes	No	Gaucoma	Yes	No
Blurred Vision - Near	Yes	No	Headaches	Yes	No
Burning Eyes	Yes	No	Itching Eyes	Yes	No
Cataracts	Yes	No	Light Sensitive	Yes	No
Color Vision Poor	Yes	No	Loss of Vision	Yes	No
Crossed Eyes	Yes	No	Migrain Headaches	Yes	No
Discharge from Eyes	Yes	No	Night Vision Poor	Yes	No
Dizzy Spells	Yes	No	Red Eyes	Yes	No
Double Vision	Yes	No	Seeing Halos	Yes	No
Dry Eyes	Yes	No	Seeing Flashes	Yes	No
Eye Infection	Yes	No	Temporary Loss of Vision	Yes	No
Eye Injury	Yes	No	Twitching Eyelid	Yes	No
Eye Strain	Yes	No	Vision Poor	Yes	No
Fainting Spells, Blackouts	Yes	No	Watering Eyes	Yes	No

Medications

Allergies

List the medications you are currently taking, including eye drops:

Pharmacy Name: _____

Phone: _____

List your allergies to medications or other substances:

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.

	Yourself		Family Member			Yourself		Family Member	
AIDS/HIV	Yes	No	Yes	No	Hepatitis (Type____)	Yes	No	Yes	No
Arthritis	Yes	No	Yes	No	High Blood Pressure	Yes	No	Yes	No
Artificial Heart Valve	Yes	No	Yes	No	Kidney Disease	Yes	No	Yes	No
Asthma	Yes	No	Yes	No	Lazy Eye	Yes	No	Yes	No
Bleeding	Yes	No	Yes	No	Lupus	Yes	No	Yes	No
Blindness	Yes	No	Yes	No	Migraine Headaches	Yes	No	Yes	No
Cancer	Yes	No	Yes	No	Pacemaker	Yes	No	Yes	No
Cataracts	Yes	No	Yes	No	Poor Color Vision	Yes	No	Yes	No
Chemical Dependency	Yes	No	Yes	No	Retinal Disease	Yes	No	Yes	No
Diabetes	Yes	No	Yes	No	Rheumatic Fever	Yes	No	Yes	No
Drug Sensitivity	Yes	No	Yes	No	Shingles	Yes	No	Yes	No
Emphysema	Yes	No	Yes	No	Skin Conditions	Yes	No	Yes	No
Epilepsy	Yes	No	Yes	No	Stroke	Yes	No	Yes	No
Eye Surgery	Yes	No	Yes	No	Thyroid Conditions	Yes	No	Yes	No
Glaucoma	Yes	No	Yes	No	Tuberculosis	Yes	No	Yes	No
Hay Fever	Yes	No	Yes	No	Turned Eye	Yes	No	Yes	No
Heart Condition	Yes	No	Yes	No	Are you pregnant?_____	Number of Children_____			
					Tobacco use_____	Alcohol Use_____			

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____ 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 or the 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 agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible physician or supplier agrees 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.