Dr. Angela Howell & Dr. Casey Wells
EyeCare Registration and History Form

Patient Information

Date: _____

Patient: _____

Adress: _____

_____

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

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

_____
_____
_____
_____
_____

Pharmacy Name: _____
Phone: _____

Allergies

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 informaiton 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.