Illinois Eye Associates

PATIENT INFORMATION SHEET (PLEASE PRINT)

Patient Name: Miss. ☐ Ms. ☐ Mrs. ☐ Mr. Dr. _____ *(Last)* _____ *(First)* _____ *(MI)*

Patient Date of Birth: _____ *(mm/dd/yy)*

Address: _____ *(Street)* _____ *(City)* _____ *(State)* _____ *(Zip code)*

Home Phone:(____)_____-_____ Cell Phone:(____)_____-_____

Work Phone: (____)_____ E-Mail: _____

Preferred Contact (please circle) HOME CELL WORK TEXT E-MAIL

Policy Holder Name_____Policy Holder Date of Birth:_____

Policy Holder Social Security #:_____-_____-_____

Government/Insurance Required Information (Please Circle)

Primary Language: English Spanish French Other:_____

Race: White/Caucasian
Native Hawaiian or Pacific Islander
Other_____
Black or African American
American Indian or Alaska Native Asian
Declined to Answer

Ethnicity: Not Hispanic or Latino
Unknown
Hispanic or Latino
Declined to Answer

Emergency Contact Person : _____ Address:_____

Emergency Contact Phone #:_____ Relationship to Patient:_____

INSURANCE AUTHORIZATION:

I certify that I, and/or my dependent(s) have insurance coverage and assign directly to Illinois Eye Associates, Ltd. all insurance benefits for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or personally. I authorize the use of my signature on all insurance submissions. If my bill is not paid by insurance, I understand I am responsible for any charges. A $25 fee will be applied to all checks with insufficient funds. I am also aware that should my bill be sent to a collection agency due to failure to pay or arrange payments, a fee of 33% of the total bill will be applied to my balance.

Illinois Eye Associates may use my health care information and may disclose such information to the insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. I further consent to the disclosure of my health information in order for another provider or health care entity to conduct health care operations, including quality assessment and reviewing the competence of health care professionals. I consent to allowing Illinois Eye Associates to obtain my previous records from other health care providers if deemed necessary for my care.

I further acknowledge that Illinois Eye Associates, Ltd. has made available to me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

Signature: _____ **Date:** _____ Relationship to Patient:_____

TURN SHEET OVER

Illinois Eye Associates

NEW PATIENT EXAMINATION/MEDICAL HISTORY

Ocular History

Date of Last Eye Exam: _____ Name of Previous Eye Doctor: _____

Age of Current Glasses: _____ Type of Glasses: ☐ Distance ☐ Reading ☐ Progressive Bifocal ☐ Safety

Do you wear Contact Lenses? ☐Yes ☐ No Do you sleep in your contact lenses? ☐Yes ☐ No

Contact Lens Solution: _____

Brand/Type of Contact Lenses: _____

Prescription (if known) R: _____ L: _____

Have **you** ever had *any* of the following?		Which Eye	Date(s)	Have **relatives** had any of the following? Who?
* Cataract Surgery	☐Yes ☐ No	☐ Right ☐ Left	_____	☐Yes ☐ No _____
* Laser Surgery	☐Yes ☐ No	☐ Right ☐ Left	_____	☐Yes ☐ No _____
* Retinal Detachment	☐Yes ☐ No	☐ Right ☐ Left	_____	☐Yes ☐ No _____
*Glaucoma	☐Yes ☐ No	☐ Right ☐ Left	_____	☐Yes ☐ No _____
*Eye Injury	☐Yes ☐ No	☐ Right ☐ Left	_____	☐Yes ☐ No _____
*Lazy or Turned Eye	☐Yes ☐ No	☐ Right ☐ Left	_____	☐Yes ☐ No _____
*Other Eye Surgeries	☐Yes ☐ No	☐ Right ☐ Left	_____	☐Yes ☐ No _____

Other Eye Problems: _____

Primary Care Physician: _____

Location : _____ Phone #: _____

Medical History/ Review of Systems

Please List Drug Allergies or write "No Known":

_____

Diabetes:	☐Yes ☐ No
High Blood Pressure:	☐Yes ☐ No
Endocrine (Thyroid Disease):	☐Yes ☐ No
Heart Problems (Irregular, CHF, Surgery):	☐Yes ☐ No
Lung/Breathing Problems (Asthma, COPD):	☐Yes ☐ No
Gastrointestinal Problems (Reflux):	☐Yes ☐ No
Kidney Problems:	☐Yes ☐ No
Arthritis:	☐Yes ☐ No
Neurologic Problems (Seizure,Migraine):	☐Yes ☐ No
Mood Disorders (Depression, Anxiety):	☐Yes ☐ No
Blood Disorders (Anemia, Sickle Cell):	☐Yes ☐ No
HIV / AIDS:	☐Yes ☐ No
Cancer (Type_____):	☐Yes ☐ No
Other_____	

Please List Current **Medications:**
(Name, Strength, and Reason Used)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please List Any **Eye-drops** Used
(Name, Strength, and Reason Used)

_____
_____
_____
_____

Do you drive?	☐Yes ☐ No
Do you smoke?	☐Yes ☐ No
Do you drink alcohol?	☐Yes ☐ No
Are you pregnant?	☐Yes ☐ No

How Did You Hear About This Office? *(Please check all that apply):*

☐ Newspaper ☐ Yellow Pages ☐ Screening ☐ Location ☐ Web Site

Other: _____