Welcome to Effingham Eye Care

Today's Date:_____ **Circle One:** ☐ Miss ☐ Mrs. ☐ Ms. ☐ Mr. ☐ Dr. ☐ Rev.

Last Name:_____, First Name:_____, MI:_____

Street Address:_____

City:_____, State:_____ Zip Code:_____

Home Phone: _____ Day Phone: _____ Cell Phone: _____

Date of Birth:____ / _____ / _____ Age:_____ Nickname: _____

Patient's SSN:_____ - _____ - _____ Guardian/Spouse's Name (if applicable): _____ _____

Employer / School:_____ Occupation / Grade: _____

Insured's Name: _____ Insured's Date of Birth: _____

Insured's SSN: _____ - _____ - _____

**Email Address:_____
(Saves money, time, and trees... For appointment reminders / newsletter – opt out anytime within email.)

What is the major purpose of this visit?_____

Whom may we thank for referring you to our office?_____

If not referred, how did you hear about our office for your eye health needs?

☐ Another Doctor ☐ Insurance ☐ Web: _____ ☐ Other: _____

********** MEDICAL HISTORY QUESTIONNAIRE **********

Last Eye Exam:_____ Last Medical Exam:_____

Name of Medical Doctor:_____ Dr.'s Phone:_____

Medical History Do you have any allergies to medications? ☐ No ☐ Yes If yes, please list :_____

_____

List any medications you take (including oral contraceptives, aspirin, and over the counter medications):

_____

_____

List all major injuries, surgeries and / or hospitalizations you have had:_____

_____

List any eye problems or surgeries you have had: _____

Females, are you pregnant or nursing? ☐ No ☐ Yes

Do you currently wear glasses? ☐ No ☐ Yes Use of glasses: ☐ Full-time ☐ Reading Only ☐ Distance Only

Do you wear contacts? ☐ No ☐ Yes If no, are you interested in wearing contacts? ☐ No ☐ Yes

Do you remove your contacts daily? ☐ No ☐ Yes If not, how often do you remove them? _____

How often do you discard your contacts (*weekly, bi-weekly, monthly)?* _____

Social History

This information is kept strictly confidential; however, you may discuss his portion directly with the doctor if you prefer.

☐ Yes, I would prefer to discuss my Social History information directly with my doctor.

Do you drive? ☐ No ☐ Yes If yes, do you have visual difficulty when driving? ☐ No ☐ Yes If yes, please describe:

_____

Do you use tobacco products? ☐ No ☐ Yes If yes, type / amount / how long:_____
Do you drink alcohol? ☐ No ☐ Yes If yes, type / amount / how long:_____
Do you use illicit drugs? ☐ No ☐ Yes If yes, type / amount / how long:_____

Have you ever been exposed to or infected with: ☐ Hepatitis ☐ HIV ☐ TB ☐ Syphilis

Family History

Is there a family history (parents, grandparents, siblings, children) for any of the following conditions?

☐ Blindness ☐ Crossed Eyes ☐ Glaucoma ☐ Macular Degeneration ☐ Retinal Detachment/Disease

Other _____

Review of Systems

Do **YOU** currently have problems in any of the following areas:

	NO	YES
CONSITUTIONAL		
Fever, Weight Loss/Gain	☐	☐
INTEGUMENTARY (Skin)	☐	☐
NEUROLOGICAL		
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
EYES		
Loss of Vision	☐	☐
Blurred Vision	☐	☐
Distorted Vision/Halos	☐	☐
Loss of Side Vision	☐	☐
Double Vision	☐	☐
Dryness	☐	☐
Mucous Discharge	☐	☐
Redness	☐	☐
Sandy/Gritty Feeling	☐	☐
Itching	☐	☐
Burning	☐	☐
Foreign Body Sensation	☐	☐
Excess Tearing/Watering	☐	☐
Glare/Light Sensitivity	☐	☐
Eye Pain or Soreness	☐	☐
Chronic Infection of Eye or Lid	☐	☐
Sties or Chalazion	☐	☐
Flashes/Floaters in Vision	☐	☐
Tired Eyes	☐	☐
ENDOCRINE		
Thyroid/Other Glands	☐	☐

	NO	YES
EARS, NOSE, MOUTH, THROAT		
Allergies/Hay Fever	☐	☐
Sinus Congestion	☐	☐
Dry Mouth	☐	☐
PSYCHIATRIC		
Depression	☐	☐
Mental Illness	☐	☐
RESPIRATORY		
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
VASCULAR/CARDIOVASCULAR		
Diabetes	☐	☐
Heart Pain	☐	☐
High Blood Pressure	☐	☐
Vascular Disease	☐	☐
GASTROINTESTINAL		
Diarrhea	☐	☐
Constipation	☐	☐
GENITOURINARY		
Genitals/Kidney/Bladder	☐	☐
BONES/JOINTS/MUSCLES		
Rheumatoid Arthritis	☐	☐
Muscle Pain	☐	☐
Joint Pain	☐	☐
LYMPHATIC/HEMATOLOGIC		
Anemia	☐	☐
Bleeding Problems	☐	☐
ALLERGIC/IMMUNOLOGIC	☐	☐

If you answered YES to any of the above or have a condition not listed, please explain:

_____

_____

_____

INSURANCE INFORMATION

Insurance Company 1) _____ 2) _____
Primary Insurance Secondary Insurance

I hereby authorize the release of any information acquired in the course of my examination or treatment to my insurance company.

I hereby authorize payment directly to Effingham Eye Care for my medical benefits, if any, otherwise payable to me for services rendered.

I permit a copy of this authorization to be used in place of the original.

Signed _____ Date _____

BILLING/COLLECTIONS POLICY

Payment for all services is due at the time services are rendered. If, however, arrangements have been made to accept your insurance as payment, we will bill your insurance company directly. In the event the insurance company does not pay, the patient is held solely responsible for the bill. Although we are more than happy to file an insurance claim on your behalf and answer any questions about a specific claim, COVERAGE ISSUES can only be addressed by your employer or group plan administrator. We cannot act as a mediator with the carrier or your employer.

I have read and agree to this financial policy.

Signed _____ Date _____

DILATION CONSENT

As part of a routine examination, Dr. Freeman elects to dilate every patient to rule out any eye diseases that may be present with or without symptoms. There is no additional charge for this procedure. It will typically affect vision for approximately 2-4 hours. For the most part, your eyes will be sensitive to light. We will happily supply you with a pair of dilation glasses to aid in your comfort. Also, you may have difficulty seeing things up close while your eyes are dilated. Usually, distance vision is not affected. However, if you feel uncomfortable with your vision after being dilated, please be sure to tell our staff, and we will be happy to contact someone for you.

If you elect to decline dilation, we ask that you check the box below to indicate such. But remember that a comprehensive examination has not been performed unless you have been dilated.

☐ I give my permission to be dilated during my examination.

☐ I choose to DECLINE being dilated during my examination.

Signed _____ Date _____