Welcome to Family Eye Care of Topeka

Please fill out the entire form. This information is kept strictly confidential.

Name (First,MI,Last)____ Today's Date:_____/_____/_____

Street____________________________________ City______________ State_________ Zip________________

Social Sec. #_________________________________ **Date of Birth:_______/_______/______** Age:______________

Home Phone # (_______)_______________________ Marital Status: M S D W Sex: M F

Work/Cell Phone # (_______)____________________ Employer:______________ Occupation:________________

Last **Medical** Exam:______________ Dr. Name:____________ Last **Eye** Exam:__________ Dr. Name:_____________

Name of Insured:______________________________________ Insured's Soc. Sec. #_____________________

Responsible Party:__________________________ Phone #________________ Relationship to patient:_________

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

Please list other family members in the home and ages:____

Do you wear **glasses**? NO YES If YES, how old is your current pair of lenses?______________________

Circle any problems you have with glasses: Glare Night Vision Computer Use Bright Sunlight Scratches

Do you wear **contact lenses**: Rigid Soft How often do you replace your contacts?___________________

MEDICATIONS AND PURPOSE OF MEDICATIONS:

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MEDICATION ALLERGIES AND REACTION:

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____

List major surgeries, illness, and/or injuries, please include dates:

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Are you pregnant and/or nursing? ☐ Yes ☐ No

OCULAR HISTORY Have you ever had any of the following conditions?

Crossed Eyes	☐	Itching	☐	Prominent Eye	☐
Retinal Disease	☐	Flashes	☐	Eye Injury	☐
Eye Pain	☐	Droopy Eyelid	☐	Burning	☐
Floaters	☐	Eye Infection	☐	Glaucoma	☐
Lazy Eye	☐	Tearing	☐	Double Vision	☐
Cataracts	☐	Halos	☐	Redness	☐

FAMILY HISTORY Please note relationship to patient: M=Mother F=Father S=Sibling GP=Grandparent

Blindness	☐	_______	Retinal Disease	☐	_______	Kidney Disease	☐	_______
Cataract	☐	_______	Arthritis	☐	_______	Lupus	☐	_______
Glaucoma	☐	_______	Cancer	☐	_______	Thyroid Disease	☐	_______
Lazy Eyes	☐	_______	Diabetes	☐	_______			
Macular Degeneration	☐	_______	Heart Disease	☐	_______			
Retinal Detachment	☐	_______	High Blood Pressure	☐	_______			

Other Health Problems: ☐ ____

SOCIAL HISTORY

Do you use tobacco products? No Yes Type/Amount/How long?____________________

Do you use illegal drugs? No Yes Type/Amount/How long?____________________

Have you ever been exposed to or infected with: NONE Herpes HIV Hepatitis Syphilis Gonorrhea

MEDICAL HISTORY: Please check any conditions that apply to you and provide information if needed.

Fever, Weight Loss/Gain ☐

Skin Condition ☐

Neurological

- Headaches ☐
- Migraines ☐
- Seizures ☐

EYES:

- Loss of Vision ☐
- Blurred Vision ☐
- Distorted Vision ☐
- Dryness ☐
- Mucous discharge ☐
- Sandy/Gritty Eyes ☐
- Foreign Body Sensation ☐
- Glare/Light sensitive ☐
- Chronic Eye/Lid Infection ☐
- Styes or Chalazia ☐
- Flashes/Floaters ☐
- Tired Eyes ☐
- Itching ☐
- Excess Tearing/Watery ☐

Psychiatric

- Anxiety ☐
- ADD/ADHD ☐
- Depression ☐

Immunologic

- Lupus, Sjogrens, HIV ☐

OTHER: ____

____

Ears, Nose, Throat

- Allergies/Hay Fever ☐
- Sinus Congestion ☐
- Runny Nose ☐
- Post-Nasal Drip ☐
- Chronic Cough ☐
- Dry Throat/Mouth ☐

Respiratory

- Asthma ☐
- Chronic Bronchitis ☐
- Emphysema ☐

Vascular/Cardiovascular

- Diabetes ☐
- Heart Disease ☐
- High Blood Pressure ☐
- High Cholesterol ☐
- Vascular Disease ☐

Gastrointestinal

- Diarrhea/Acid Reflux ☐
- Constipation ☐

Genitourinary

- Genitals/Kidneys/Bladder ☐

Bones/Joints/Muscles

- Rheumatoid Arthritis ☐
- Muscle Pain ☐
- Joint Pain ☐

Lymphatic/Hematological

- Anemia ☐

Endocrine

- Thyroid/Other Glands ☐

If you answered yes to any of the conditions above, please explain:

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Privacy Practices Acknowledgment: I have received, read, understand, and give my consent to your Notice of Privacy Practices containing a description of the uses and disclosures of my health information.

Patient Authorizations: I hereby authorize the release of any information required to process any and all claims for reimbursement on my behalf, and authorize payment of my medical, surgical and optical insurance benefits to Family Eye Care of Topeka, P.A.. I understand I am financially responsible for any charges whether or not paid by said insurance, including all items and services which are determined by the health care service plans not to be covered. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Family Eye Care of Topeka, P.A. A copy of this authorization may be used in place of the original. I also agree that if there is a need for legal action to be brought against any insurance company or other guarantors, I will be responsible for instigating such action. If an account is sent for collection, I agree to pay collection expenses including but not limited to a $30 service charge, court costs, attorney fees, and collection agency fees. If my account is over 60 days old, a 1.5% monthly interest charge will be added. If the patient is a minor, I authorize Family Eye Care of Topeka, and whomever they may designate as their assistants to administer treatment as they deem necessary.

I have read and understand this form. I am signing it voluntarily.

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Patient Signature (or parent/guardian) Date