



WELCOME TO CAROLINA FAMILY EYECARE

Last Name: _____ First Name: _____ M.I.: _____
 Address: _____ City: _____ Zip: _____
 Telephone: Work: _____ Home: _____
 Date of Birth: _____ Gender: M / F Today's Date: _____
 Social Security #: _____ - _____ - _____ Marital Status: Single/ Married/ Other
 Employer _____ Occupation _____
 Date of Last Eye Exam: _____ By Whom: _____
 Email address: _____

Medical Information

Reason for Today's Visit: _____
 How is your general health? _____

Do you have problems with any of these systems? (*Please circle all that apply*)

| | | | | | |
|------------------|-----|----------------------|-----|----------------------|-----|
| Gastrointestinal | Y/N | Nervous | Y/N | Mental | Y/N |
| Ears/Nose/Throat | Y/N | Genitourinary | Y/N | Endocrine(glands) | Y/N |
| Cardiovascular | Y/N | Musculoskeletal | Y/N | Blood/Lymph | Y/N |
| Respiratory | Y/N | Integumentary (skin) | Y/N | Allergic/Immunologic | Y/N |

Please explain _____
 Diabetes? Y/N Type _____ Insulin: Y/N Date of Diagnosis _____
 All allergies (medicine, food, environmental, etc.) _____
 Headaches? Y/N List location and frequency: _____
 List any other health problems: _____
 Current Medications: _____
 List all operations and dates: _____
 Do you use: Cigarettes/Tobacco Y/N Alcohol? Y/N Other substances? Y/N
 Family Doctor and location: _____
 Date of last tetanus shot: _____

Family History

| | |
|-----------------------------------|------------------------------------|
| High blood pressure Y/N Relation: | Macular Degeneration Y/N Relation: |
| Diabetes Y/N Relation: | Retinal detachment Y/N Relation: |
| Glaucoma Y/N Relation: | Cataracts Y/N Relation: |

Personal Eye Information

Eye condition(s)? Y/N What kind? _____ Date: _____
 Have you had any eye operations? Y/N Type _____ Date: _____
 Have you had an eye injury? Y/N Kind _____ Date: _____
 Do you have glaucoma? Y/N Cataracts? Y/N Dry Eye? Y/N Blurred Vision? Y/N
 Other Eye Concerns? Y/N What Kind? _____
 Do you wear glasses? Y/N Contact Lenses? Y/N Type _____
 Additional information _____
 Whom may we thank for referring you? _____



INSURANCE INFORMATION

Do you have vision or health insurance? Y / N

Name of Insurance: _____

Name which the insurance coverage is under: Name: _____ self/spouse/parent

Insured's ID#: _____

Date of birth of policyholder: _____

I hereby authorize Carolina Family Eyecare to release any information to process this claim. I also authorize my insurance benefits be paid directly to the physician, and I understand I am financially responsible for non-covered services. I acknowledge that all information above is complete and correct.

Signed

Date

PLEASE READ:

We make every effort to verify insurance coverage before the patient is seen. In our experience, phone verification does NOT guarantee reimbursement in a minority of cases. In such cases we will file and re-file the claim. If the claim is denied after the second filing a bill will be sent. At this point you may contact your insurance carrier if you feel that the claim was denied in error.

I acknowledge that I received a copy of the Notice of Privacy Practices, HIPPA.

Signature _____ Date _____

I authorize Carolina Family Eyecare to leave messages regarding my account:

YES NO Initials: _____

Please list names of anyone that you give permission for Carolina Family Eyecare to speak with regarding your account. _____

Initials: _____ Date: _____