EyeCare Texas
The Contact Lens Specialists

PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information. Please Print. All information will be confidential.

Date

Patient Name (FIRST / MI / LAST) — Patient #

SS#/SIN ☐Male ☐Female Birthdate — Home phone

Address — Cell phone

City — State/Prov. — Zip/P.C. — Email

Check appropriate box: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Patient or parent/guardian's employer — Work phone

Business address — City — State/Prov. — Zip/P.C.

Spouse or parent/guardian's name — Employer — Work phone

If patient is a student, name of school/college — City — State/Prov.

Whom may we thank for referring you?

Person to contact in case of emergency — Phone

VISION INSURANCE INFORMATION (PRIMARY)

Name of insured — Relationship to patient

Birthdate — SS#/SIN — Date employed

Name of employer — Work phone

Address of employer — City — State/Prov. — Zip/P.C.

Insurance company — Group # — Union or Local #

Insurance Co. Address — City — State/Prov. — Zip/P.C.

How much is your deductible? — How much have you used? — Max. annual benefit?

MEDICAL INSURANCE INFORMATION (SECONDARY)

Name of insured — Relationship to patient

Birthdate — SS#/SIN — Date employed

Name of employer — Work phone

Address of employer — City — State/Prov. — Zip/P.C.

Insurance company — Group # — Union or Local #

Insurance Co. Address — City — State/Prov. — Zip/P.C.

How much is your deductible? — How much have you used? — Max. annual benefit?

PERSONAL EYE INFORMATION

Do you have any eye conditions or problems? ☐ Yes ☐ No — What kind?

Have you had any eye operations? ☐ Yes ☐ No — Type — Date

Have you had an eye injury? ☐ Yes ☐ No — Kind — Date

Do you have glaucoma? ☐ Yes ☐ No — Cataracts? ☐ Yes ☐ No — Dry eyes? ☐ Yes ☐ No

Macular degeneration? ☐ Yes ☐ No — Retinal detachment? ☐ Yes ☐ No — Blurred vision? ☐ Yes ☐ No

Do you wear glasses? ☐ Yes ☐ No — Contact lenses? ☐ Yes ☐ No — Type

Additional information

HEALTH HISTORY

Fill out this information to the best of your ability. Providing incorrect information can be dangerous to your health. Please inform our office when there are any changes in the medical information you provide below.

Do you currently wear glasses or contacts? ☐ All the time ☐ Occasionally ☐ No

Do you wear them for ☐ Reading ☐ TV ☐ Computer Work ☐ Driving

Review of Systems: Please indicate any personal history below:

☐ **Constitutional Symptoms**
- Good general health lately...... No Yes
- Recent weight change.......... No Yes
- Fever.............................. No Yes
- Fatigue........................... No Yes

☐ **Ears/Nose/Mouth/Throat**
- Earaches or drainage........... No Yes
- Chronic sinus problem or rhinitis No Yes
- Nose bleeds...................... No Yes
- Mouth sores...................... No Yes
- Bleeding gums.................... No Yes
- Bad breath or bad taste......... No Yes
- Hearing loss or injury........... No Yes
- Sore throat or voice change.... No Yes

☐ **Neurological**
- Numbness or tingling sensation No Yes
- Paralysis......................... No Yes
- Headaches........................ No Yes
- Light headed or dizzy........... No Yes
- Convulsions or seizures........ No Yes
- Tremors.......................... No Yes
- Head injury...................... No Yes

☐ **Hematologic/Lymphatic**
- Anemia........................... No Yes
- Bleeding or bruising tendency.. No Yes
- Slow to heal after cut........... No Yes
- Phlebitis......................... No Yes
- Past transfusion................. No Yes
- Enlarged glands.................. No Yes

Use of Alcohol:
- ☐ Never
- ☐ Rarely
- ☐ Moderate
- ☐ Daily

Use of Tobacco:
- ☐ Never
- ☐ Previously, but not in the past _____ year(s)
- ☐ Yes.Current packs/day: _____

☐ **Respiratory**
- Do you have a history of TB -Tuberculosis?................ No Yes
- Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks) .... No Yes
- Chronic or frequent coughs ..... No Yes
- Shortness of breath.............. No Yes
- Wheezing......................... No Yes
- Spitting up blood................. No Yes

☐ **Gastrointestinal**
- Loss of appetite.................. No Yes
- Change in bowel movements.... No Yes
- Frequent diarrhea .... No Yes
- Nausea or vomiting.............. No Yes
- Painful bowel movements or constipation .... No Yes
- Rectal bleeding or blood in stool No Yes
- Abdominal pain .... No Yes

☐ **Psychiatric**
- Memory loss or confusion........ No Yes
- Depression........................ No Yes
- Nervousness...................... No Yes
- Insomnia .... No Yes

☐ **Cardiovascular**
- Heart trouble..................... No Yes
- Chest pain or angina pectoris.... No Yes
- Palpitation........................ No Yes
- Shortness of breath w/walking or lying down....................... No Yes
- Swelling of feet, ankles or hands No Yes

☐ **Musculoskeletal**
- Joint pain.......................... No Yes
- Joint stiffness or swelling .... No Yes
- Muscle pain or cramps .... No Yes
- Weakness pain or cramps .... No Yes
- Back pain .... No Yes
- Cold extremities .... No Yes
- Difficulty in walking .... No Yes

☐ **Allergic/Immunologic**

History of skin reaction or other adverse reaction to:
- Penicillin or other antibiotics ..... No Yes
- Morphine, Demerol, or other narcotics............................ No Yes
- Novocain or other anesthetics ... No Yes
- Aspirin or other pain remedies .. No Yes
- Tetanus antitoxin or other serums .... No Yes
- Iodine, Merthiolate or other antiseptics .... No Yes

Other drugs/medications: _______________

Have you ever taken Fen-Phen/Redux.................. No Yes

Known food allergies: _______________

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, City, State/Prov.

Medications (include Non-Perscription) _______________

Family Medical History:	Age	Medical/Eye Diseases	If Deceased, Cause of Death
Self			
Father			
Mother			
Siblings			
Spouse			
Children			

AUTHORIZATION & RELEASE

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X _______________________________ _______________

Signature of patient (or parent/guardian if minor) Date

ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICE

The law requires that Eyecare Texas make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- ☐ I have read or had explained to me Eyecare Texas's Notice of Privacy Practice and agree to continue my care with Eyecare Texas under said terms.
- ☐ I was given the opportunity to read Eyecare Texas's Notice of Privacy Practice and declined but wish to continue my care with Eyecare Texas under the terms of Eyecare Texas's privacy policies.
- ☐ I have read or had explained to me Eyecare Texas's Notice of Privacy Practice and do not wish to continue my care with Eyecare Texas under said terms.
- ☐ The Notice of Privacy Practice could not be read due to the emergent nature of the care or other reason described as

  ____
  ____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

________________________________ ________________
Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship

__________________________ ____________________
Representative Relationship to Patient