

# Piedmont EyeCare Assoc

## Welcome Back To Our Office

Welcome to Piedmont EyeCare Assoc. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

Mr.  Miss  Mrs.  Ms.  Male  Female

\_\_\_\_\_  
 First Name MI Last Name Preferred Name

\_\_\_\_\_  
 Street Address City State Zip

\_\_\_\_\_  
 Social Security Number Date of Birth Home Phone - Include Area Code Work Phone

\_\_\_\_\_  
 Email Address Spouse or Parent(s) Name Person Responsible for Account

\_\_\_\_\_  
 Emergency Contact Emergency Phone

How were you referred to our office?

Phone Book  School  Advertisement  Patient (Please Name) \_\_\_\_\_  
 Insurance Listing  Drive by  Other \_\_\_\_\_  Doctor (Please Name) \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION**

\_\_\_\_\_  
 Name and Address of Primary Insurance Company City State Zip

M  F  \_\_\_\_\_  
Insured's First Name MI Insured's Last Name

\_\_\_\_\_  
 Insured's Identification Number Group Number Insured's Date of Birth

**Patient Relationship to Insured**

Self  Spouse  Child  Other

**Patient Status**

Single  Married  Other  
 Full Time Student  Part Time Student  Employed

**SECONDARY INSURANCE INFORMATION**

\_\_\_\_\_  
 Name and Address of Secondary Insurance Company City State Zip

M  F  \_\_\_\_\_  
Insured's First Name MI Insured's Last Name

\_\_\_\_\_  
 Insured's Identification Number Group Number Insured's Date of Birth  Self  Spouse  Child  Other

**Patient Relationship to Insured**

**Please Read:**

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to . I understand that will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date

Name

# Piedmont EyeCare Assoc PATIENT HISTORY AND INFORMATION

## PRIMARY CARE PHYSICIAN

Primary Care Physician and Clinic Name

Address of Primary Care Physician

City

State Zip

Phone

## REFERRING PHYSICIAN

Referring Physician and Clinic Name

Address of Referring Physician

City

State Zip

Phone

## HEALTH HISTORY

What is the main reason for today's exam ? \_\_\_\_\_ When was your last exam ? \_\_\_\_\_

When was your last health exam ? \_\_\_\_\_

Past Illnesses or Injuries: \_\_\_\_\_

Past Surgeries: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Current Eye Drops: \_\_\_\_\_

Medicines that cause reactions or sensitivities: \_\_\_\_\_

Specific Allergies: \_\_\_\_\_

## EYE HISTORY

Glaucoma  Yes  No

Cataract  Yes  No

Macular Degeneration  Yes  No

Retinal Detachment  Yes  No

Color Blindness  Yes  No

Headaches  Yes  No

Glare/Light Sensitivity  Yes  No

Tired Eyes  Yes  No

Amblyopia (Lazy Eye)  Yes  No

Burning  Yes  No

Dryness  Yes  No

Excess Tearing/Watering  Yes  No

Eye Pain or Soreness  Yes  No

Foreign Body Sensation  Yes  No

Infection of Eye or Lid  Yes  No

Itching  Yes  No

Mucous Discharge  Yes  No

Drooping Eyelid  Yes  No

Redness  Yes  No

Sandy or Gritty Feeling  Yes  No

Strabismus (Crossed Eyes)  Yes  No

Blurred Vision Distance  Yes  No

Blurred Vision Near  Yes  No

Distorted Vision (halos)  Yes  No

Double Vision  Yes  No

Floaters or Spots  Yes  No

Fluctuating Vision  Yes  No

Loss of Vision  Yes  No

Loss of Side Vision  Yes  No

## GENERAL HEALTH CONDITION

Fever  Yes  No

Weight Loss  Yes  No

Other Symptoms  Yes  No

Ears,Nose,Throat  Yes  No

Cardiovascular (high blood pressure etc.)  Yes  No

Respiratory (Asthma)  Yes  No

Gastrointestinal  Yes  No

Kidney  Yes  No

Muscles,Bones, Joints  Yes  No

Skin  Yes  No

Neurological (Multiple Sclerosis)  Yes  No

Anxiety or Depression  Yes  No

Endocrine (Thyroid, Diabetes)  Yes  No

Blood/Lymph  Yes  No

Allergic  Yes  No

Are you?  Pregnant

Nursing

## FAMILY HISTORY

Amblyopia (Lazy Eye)  Yes  No

Blindness  Yes  No

Cataract(s)  Yes  No

Color Blindness  Yes  No

Glaucoma  Yes  No

Macular Degeneration  Yes  No

Retinal Detachment  Yes  No

Strabismus (Eye Turn)  Yes  No

Arthritis  Yes  No

Cancer  Yes  No

Diabetes  Yes  No

Heart Disease  Yes  No

High Blood Pressure  Yes  No

Kidney Disease  Yes  No

Lupus  Yes  No

Stroke  Yes  No

Thyroid Disease  Yes  No

Others  Yes  No

Name \_\_\_\_\_

# Piedmont EyeCare Assoc MEDICAL HISTORY QUESTIONNAIRE

### SOCIAL HISTORY

Current Occupation : \_\_\_\_\_ Years \_\_\_\_\_ Employer \_\_\_\_\_

### SPECTACLE LENS HISTORY

Do you use a computer?      Yes    No   How many hours/day? \_\_\_\_\_   Distance from Computer? \_\_\_\_\_

Do you drive?      Yes    No   Mileage to work each way? \_\_\_\_\_   Do you have glare problems?      Yes    No

Do you have visual difficulty when driving?      Yes    No

Do you have problems with night vision?      Yes    No

Do you currently wear glasses ?      Yes    No   Since \_\_\_\_\_

Type of glasses      Full Time    Part Time    Distance    Close

Glasses Owned

Single Vision    Bifocals    Trifocals    Back-up Glasses    Safety Glasses    Sports Glasses    Progressive

Have you had trouble in the past with glasses?      Yes    No   \_\_\_\_\_

Do you wear sunglasses?      Yes    No   Are your sun glasses your current prescription ?      Yes    No

### SPECIAL EYEWEAR NEEDS

Computer (special prescriptions, special anti-glare tints or coatings)    Safety Glasses (gardening, woodworking, welding)  
 Occupational (mechanics, plumbers, pilots)    Sports/Hobbies (racquet sports, motorcycle)

### CONTACT LENS HISTORY

Have you ever tried to wear contact lenses?      Yes    No   Reason for stopping? \_\_\_\_\_

Do you currently wear contact lenses?      Yes    No   Since \_\_\_\_\_

If not a contact lens wearer, are you interested in trying contact lenses at this time ?      Yes    No

Type and brand of contact lenses \_\_\_\_\_   Today's wearing time ? \_\_\_\_\_

How many hours/day ? \_\_\_\_\_   How many days/week ? \_\_\_\_\_

**Please rate the following on a scale of 1-10, with 1 being POOR to 10 being EXCELLENT**

|              |       |       |                 |       |       |             |       |       |
|--------------|-------|-------|-----------------|-------|-------|-------------|-------|-------|
|              | Right | Left  |                 | Right | Left  |             | Right | Left  |
| Lens Comfort | _____ | _____ | Distance Vision | _____ | _____ | Near Vision | _____ | _____ |

What Solutions do you use?     Cleaner \_\_\_\_\_   Disinfectant \_\_\_\_\_   Enzyme \_\_\_\_\_

### SOCIAL HISTORY

Do you use nutritional supplements (vitamins etc.)?      Yes    No

Do you engage in regular exercise?      Yes    No

Do you drink alcohol ?     If yes, how much/often :    No    Occasional    1 per day    2-3/day    4+/day

Do you smoke ?     If yes, how much/often :    No    Occasional    1/2 pack/day    1 pack/day    1+ pack

Method of Tobacco Intake :      Smoking    Chewing

Do you use Illegal Drugs :      Yes    No

Hobbies/ Interests : \_\_\_\_\_

## DILATION AND PHOTOGRAPHY CONSENT

Our doctors recommend having retinal photography and pupil dilation as part of your YEARLY eye health evaluation. Retinal examination through a dilated pupil has become the standard of care for a comprehensive eye exam. Dilation allows for the inspection of the periphery of the eye for the presence of retinal detachments, tumors and other sight threatening disorders.

Digital retinal photography assists your doctor in the early detections of many disorders, including glaucoma, diabetic retinopathy, macular degeneration and high blood pressure. The digital images will be saved and compared with images from future exams. This allows your doctor to observe even the smallest change from the previous exam. Digital photography can be performed without pupil dilation and is recommended if you choose to not have your pupils dilated.

Both procedures will be performed on all patients as a part of their comprehensive eye health examination unless declined by the patient/guardian below.

**There is an additional charge of \$28.00 for digital retinal photography. If a medical diagnosis is made because of this procedure, we may be able to bill your medical insurance company or Medicare for this procedure. If your insurance company allows this procedure, you will be responsible for your normal specialist co-pay.**

\_\_\_\_\_ I decline dilation

\_\_\_\_\_ I would like to reschedule dilation with the understanding of a fee involved

\_\_\_\_\_ I decline Photography

Signature: \_\_\_\_\_ Date: \_\_\_\_\_