SPECIALTY EYE CARE MEDICAL CENTER, INC.

New Patient Information

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Cell Phone: _____

Sex: Male: ☐ Female: ☐

Birthday: _____ Age: _____

Social Security Number: _____

Driver License Number: _____ State: _____

Family Physician: _____ Phone: _____

Referred By: _____

EMPLOYMENT

Current Occupation: _____

Work Phone: _____

Employer's Name & Address: _____

Marital Status: Married: ☐ Single: ☐ Divorced: ☐ Other: ☐

Spouse's Name: _____

Spouse's Occupation: _____

Spouse's Employer Name & Address: _____

EMERGENCY CONTACT

Emergency Contact: _____ Relationship: _____

Address: _____

Contact Phone: _____

Signature: _____ Date: _____

SPECIALTY EYE CARE
MEDICAL CENTER

INSURANCE COVERAGE POLICY

As a courtesy to our patients, our office will be glad to bill your insurance company for your medical services. However, we would like you to know that the total amount due is your responsibility. We will be happy to accept payments from your insurance, but any remaining balance on your account is ultimately your responsibility. We ask that you provide us with the proper insurance forms, or below, authorizing your insurance company to remit payments directly to our office. If we do not receive any payments within (90) days of billing, you will be required to take care of your balance yourself. Thank you.

I, the undersigned, agree to the above conditions and understand that I am ultimately responsible for the total balance due.

Signature: _____ Date: _____

INSURANCE AUTHORIZATION

I, the undersigned, have insurance coverage with _____ and assign directly to **SPECIALTY EYE CARE MEDICAL CENTER, INC.** all medical benefits, if any, otherwise payable to me for services rendered. I herby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submission.

Signature: _____ Date: _____

MEDICARE AUTHORIZATION

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF **TO SPECIALTY EYE CARE MEDICAL CENTER, INC.**, FOR ANY SERVICES FURNISHED ME BY THAT PHYSICIAN. I AUTHORIZE ANY HOLD OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO HEALTH CARE FINANCING ADMINIOSTRATION ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THE BENEFITS OR THE BENEFITS THAT PAYABLE FOR RELATED SERVICES. I UNDERSTAND MY SIGNATURE REQUESTS THAT PAYMENT BE MADE AND AUTHORIZES RELEASE OF MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM. IF "OTHER HEALTH INSURANCE" IS INDICATED IN ITEM 9 OF HCFA FORM, OR ELSEWHERE ON OTHER APPROVED CLAIM FORMS OR ELECTRONICALLY SUBMITTED CLAIMS, ANY SIGNATURE OF THE INFORMATION TO THE INSURER OR AGENCY SHOWN.

Signature: _____ Date: _____

HEALTH HISTORY

Last Name _____ First Name _____

YES	NO		YES	NO	
☐	☐	ASTHMA	☐	☐	HEAD OF SPINAL INJURIES
☐	☐	KIDNEY DISEASE	☐	☐	SEIZURES, CONVULSIONS, OR FAINTING
☐	☐	TUBERCULOSIS	☐	☐	EXTENSIVE CONFINEMENT BY ILLNESS
☐	☐	DIABETES IDDM /TYPE II YRS.	☐	☐	TEMPORAL ARTHRITIS
☐	☐	INSULIN	☐	☐	SUFFERING FROM ANY OTHER DISORDER
☐	☐	MIGRAINES	☐	☐	CAROTID ARTERY-DISEASE
☐	☐	PSYCHIATRIC DISORDER	☐	☐	PERMAMNENT DEFECTS (illness or injury)
☐	☐	ANY NERVOUS DISORDER	☐	☐	(WOMEN) ARE YOU PREGNANT? Months.
☐	☐	HEART DISEASE	☐	☐	HIGH BLOOD PRESSURE
☐	☐	ULCER	☐	☐	STROKE
☐	☐	RHEUMATOID ARTHRITIS	☐	☐	HIV
☐	☐	SICKLE CELL ANEMIA	☐	☐	OTHER

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:	PLEASE LIST ALL MEDICATIONS YOU ARE ALLERGIC TO:

YOUR OCULAR HISTORY (Have you been diagnosed with any of the following in the past?)

YES	NO		YES	NO	
☐	☐	CATARACTS	☐	☐	CORNEA DISEASE
☐	☐	RETINA DISEASE	☐	☐	GLAUCOMA
☐	☐	CROSSED EYE	☐	☐	INJURY
☐	☐	IRITIS	☐	☐	OTHER EYE DISORDER

CATARACT SURGERY (Date of Surgery) ☐ Right _____ ☐ Left _____

DO YOU HAVE LENS IMPLANT? ☐ YES ☐ NO

RETINAL SURGERY (Date of Surgery) ☐ Right _____ ☐ Left _____

EXPLANATION OF ANY EYE INJURIES

_____

_____

FAMILY OCULAR HISTORY (Has anyone in your family been diagnosed with any of the following in the past?)

(NOTE TO PATINET): F – Father M – Mother P – Paternal MAT – Maternal S – Sister B – Brother
GF – Grandfather GM – Grandmother U – Uncle A – Aunt

YES	NO		YES	NO	
☐	☐	GLAUCOMA	☐	☐	DIABETES IDDM /TYPE II
☐	☐	CATARACTS	☐	☐	HEART PROBLEMS
☐	☐	CORNEA DISEASE	☐	☐	DIABETIC RETINOPATHY
☐	☐	MACULAR DEGENERATION	☐	☐	RETINAL DETACHMENT
☐	☐	RETINITIS PIGMENTOSA	☐	☐	STROKE
☐	☐	OTHER EYE PROBLEMS	☐	☐	OTHER GENERAL HEALTH PROBLEMS

SURGICAL HISTORY (Please include Date and type)

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MEDICAL CENTER