

Patient Information

Date: _____
 Patient: _____
 Street Address: _____
 City: _____
 State: _____ Zip: _____
 Sex: M F Age: _____ DOB: _____
 Single Married Widowed
 Separated Divorced
 Patient SS#: _____
 Occupation: _____
 Employer: _____
 Employer Address: _____

 Spouse's Name: _____
 DOB: _____ SS#: _____
 Occupation: _____
 Spouse's Employer: _____
 How did you hear about us? (If from another patient, who may we thank for referring you?)

Insurance

Who is responsible for this account?

 Relationship to Patient: _____
 Insurance Co.: _____
 Member ID #: _____
 Is patient covered by additional insurance? Yes No
 Subscriber Name: _____
 DOB: _____ SS#: _____
 Relationship to Patient: _____
 Insurance Co.: _____
 Member ID #: _____
Assignment and Release
 I, the undersigned, certify that I (or my dependent) have insurance coverage and have assigned directly to Campus Eye Group all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.
 Responsible Party Signature: _____

 Relationship: _____ Date: _____

Contact Information

Home: _____ Work: _____ Ext. _____ Cell Phone: _____
 Spouse's Work: _____ Best time and place to reach you: _____
 Email Address: _____ (for CEG use only)

In Case of Emergency, Contact

Name: _____ Relationship: _____
 Home Phone: _____ Work Phone: _____

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Campus Eye Group for any services furnished me by that doctor. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits 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 the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services.

Signature

Date

Medications

List any medications **and** eye drops you are currently taking:

Pharmacy Name: _____
 Phone: _____

Allergies

List your allergies to medications or other substances:

Health History

Physician's Name: _____ Date of last visit: _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following. Also place a mark to indicate if a blood relative has had any of the following problems.

	Yourself		Family Member			Yourself		Family Member	
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin Conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco Use	<input type="checkbox"/> None	<input type="checkbox"/> Medium	<input type="checkbox"/> Heavy	
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Use	<input type="checkbox"/> None	<input type="checkbox"/> Medium	<input type="checkbox"/> Heavy	
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	List all previous surgeries:				
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____				
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____				

Eye Health History

Date of last eye exam: _____

Name of doctor: _____

Do you wear glasses: Yes No
 All the time Occasionally Reading
 Driving During TV

Do you wear contacts: Yes No

Type: _____ Hours/Day: _____

Describe any problems you have with your contacts:

Place a mark on "Yes" or "No" to indicate if you have had any of the following.

Bloodshot Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Floaters or Spots	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blurred Vision- Distance	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blurred Vision - Near	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Burning Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Itching Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Light Sensitive	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Color Vision Poor	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Loss of Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Crossed Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Discharge from Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Night Vision Poor	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dizzy Spells	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Red Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Double Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seeing Halos	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dry Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seeing Flashes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eye Infection	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Temporary Loss of Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eye Injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Twitching Eyelid	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eye Strain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Vision Poor	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fainting Spells, Blackouts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Watering Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Would you be interested in receiving information about any of the following:

Laser vision correction (LASIK)? Yes No
 New contact lens technology? Yes No
 Transition lenses? Yes No
 Anti-reflective coating? Yes No