PATIENT NAME: _____ DATE: _____

REVIEW OF SYSTEMS: _____

Do you presently have any problems in the following areas? If YES, please give an explanation:

	Yes	No	Explanation of problems
EYES:			
Loss of vision	○	○	
Distorted vision	○	○	
Double vision	○	○	
Mucous discharge	○	○	
Sandy feeling	○	○	
Burning	○	○	
Excess tearing	○	○	
Glare/light sens.	○	○	
Infect. of eye/lid	○	○	
Fluctuating vision	○	○	
Blurred vision	○	○	
Loss of side vision	○	○	
Dryness	○	○	
Redness	○	○	
Itching	○	○	
Eye Pain	○	○	
Styes, chalazion	○	○	
Tired eyes	○	○	
Glaucoma	○	○	
Other	○	○	
EARS, NOSE, MOUTH, THROAT:			
Sinus congestion	○	○	
Dry mouth/throat	○	○	
Runny nose	○	○	
Other	○	○	
HEMATOLOGICAL/LYMPHATICS:			
Anemia	○	○	
Leukemia	○	○	
Other:	○	○	

	Yes	No	Explanation of problems
LUNGS:			
Shortness of breath	○	○	
Respiratory problems	○	○	
Asthma	○	○	
Other:	○	○	
NEUROLOGICAL:			
Strokes	○	○	
Headaches/migraines	○	○	
Other:	○	○	
ENDOCRINE:			
Diabetes Mellitus	○	○	
Thyroid	○	○	
Other:	○	○	
ALLERGIC/IMMU:			
Allergy symptom	○	○	
Seasonal Allergy	○	○	
Other:	○	○	
GASTROINTESTINAL:			
Stomach /Intestines	○	○	
Other:	○	○	
CARDIOVASCULAR:			
Hypertension	○	○	
Heart/blood vess.	○	○	
Other:	○	○	
MUSCULOSKELETAL:			
Muscle pain	○	○	
Arthritis	○	○	
Multiple Sclerosis.	○	○	
Other:	○	○	

If patient is child: Pregnancy full term _____ If no, detail _____ Birth weight _____

Past Medical History: (Disease, illness or injury) ex: diabetes, high blood pressure: _____

_____

_____

_____

(TURN PAGE OVER)

List any surgeries you have had in the past:

List all medications you take including dosage and how often it is taken:

PLEASE BRING CURRENT MEDICATION, INCLUDING EYE DROPS WITH YOU!

Do you have allergies to any medications: _____ Yes _____ No

If YES, list medications:

SOCIAL HISTORY:

Do you drive? . . . . . Yes No

Do you have difficulty when driving? . . . . . Yes No

Do you have a problem with night vision? . . . . . Yes No

Do you currently wear glasses? . . . . . Yes No

If YES, how long have you had the current pair? . . _____

Do you smoke? . . . . . Yes No

If YES, how many packs a day? . . . . . _____

FAMILY HISTORY:

DISEASES:	**Yes**	**No**	**Relationship to patient**
Blindness	○	○	
Cataracts	○	○	
Glaucoma	○	○	
Macular degeneration	○	○	
Retinal detachment	○	○	
Eyes crossing, turning in or out	○	○	
Diabetes	○	○	
High blood pressure	○	○	
Heart disease	○	○	
Other	○	○	

PATIENT INFORMATION RECORD

Full Legal
Name _____ Nickname _____

Home Address _____ Apt.# _____ City _____

State _____ Zip Code _____ Email Address _____

Social Security Number _____ Home Phone _____ Cell Phone _____

Date of Birth _____ Age _____ Sex: ☐ Male ☐ Female Marital Status _____
Occupation _____ Employer _____ /or Retired From _____
Employer's Address _____ Business Phone _____
PRIMARY CARE DOCTOR _____ **ADDRESS** _____
EMERGENCY CONTACT (NOT LIVING WITH YOU:) Name _____ **Phone** _____ **Relation** _____
How were you referred to this office? _____

•

Spouses Name _____ Social Security # _____
Date of Birth _____ Employer _____ Business Phone _____
Employer's Address _____

•

If the patient is a minor the following information must be completed by Parent or Guardian:
Parent or Guardian's Legal Name _____

Father's Name _____	Mother's Name _____
Father's Address _____	Mother's Address _____
S.S. # _____ DOB _____	S.S. # _____ DOB _____
Home Phone _____ Work Phone _____	Home Phone _____ Work Phone _____
Employer _____	Employer _____
Address _____	Address _____

INSURANCE INFORMATION *(Insurance cards must be presented upon each visit)*

Were you injured at work? _____ Workman's Compensation Carrier _____
Are you enrolled in a Vision Care Plan? _____ **Name of Plan** _____
Identification # _____
Subscriber's Name _____ Date of Birth _____
Subscriber's Employer _____ SS# _____
Do you have health insurance? ( ) No ( ) Yes - if yes, indicate below
Primary Insurance Name _____ Identification # _____
Subscriber's Name _____ SS# _____
Date of Birth _____ Employer _____
Secondary Insurance Name _____ Identification # _____
Subscriber's Name if different _____
Date of Birth _____ Employer _____

I hereby authorize The Eye Group of Southern Indiana to treat my dependents or myself. I also authorize The Eye Group to furnish information to Insurance Carriers concerning my/their illness and treatments. This authorization is valid as long as I am a patient of The Eye Group. I understand that I am responsible for all financial obligations of health services for the above patient, and for reimbursement and payment of claims from my insurance company. If my account is placed for collection with a third party collection agency, I agree to be responsible for pre- and post-judgment interest, attorney fees, and court costs. I understand and agree to the above terms. I have received a Notice of Privacy Practices from The Eye Group of Southern Indiana.

Signature of Patient or Responsible Party _____ **Date** _____

(OVER)

MEDICARE PATIENTS

As Medicare participating providers, **The Eye Group of Southern Indiana, LLC** accepts assignment on your insurance claims. Your signature is needed below so we may file your insurance accordingly.

Name of Insured (print) _____ Medicare Number _____

I request that payment of authorized Medicare benefits be made to me or on my behalf to **The Eye Group of Southern Indiana, LLC** for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient/Representative's Signature _____ Date _____

Medicare Secondary Insurance

Name of Insured (print) _____ Medicare Secondary Policy Number _____

I request that payment of authorized Medicare benefits be made either to me or to **The Eye Group of Southern Indiana, LLC** on my behalf for any services rendered to me by that provider. I authorize any holder of medical information about me to release to (Secondary Insurance Name) _____ any information to determine these benefits or the benefits payable for related services.

Patient/Representative's Signature _____ Date _____

MEDICAID PATIENTS

This is to acknowledge that I have been informed prior to my eye exam that Envision Optical is not a provider of optical goods and services for Indiana Medicaid patients.

Patient (or Guardian) Signature _____ Date _____