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? _____

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Spouses Name _____ Social Security # _____

Date of Birth _____ Employer _____ Business Phone _____

Employer's Address _____

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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 _____

Health History Form

Patient Name: _____ Date: _____

Who is your primary care doctor? _____

Any other specialist doctors? _____

When was your last Eye exam? _____ Where? _____

Past Medical History

Have you been diagnosed with any of the following? (Circle those that apply)

Diabetes	Atrial Fibrillation	High Cholesterol	Heart Attack
Congestive Heart Failure	High Blood Pressure	Blood Clot	Stroke
Kidney Disease	Liver Disease	Prostate Disease	Bladder issues
Cancer	COPD/Emphysema	Asthma	Thyroid Disease
Arthritis	Seasonal Allergies	Bowel Issues	Migraines

Other conditions not listed above: (please list)

_____

_____

List any surgeries you have in the past: (Include any eye surgeries or lasers)

_____

_____

List any medications that you take: (Or you can give us a copy of your medications if you have a list) Include over the counter meds and eye drops.

_____

_____

_____

_____

_____

☐ I do not take any medications (Check box if true)

List any allergies to medications: _____

☐ I do not have any medication allergies (Check box if true)

Do you smoke tobacco? ☐ Yes ☐ No ☐ Not currently, but in past

Do you drink alcohol daily? ☐ Yes ☐ No ☐ Not currently, but in past

Ocular history:

Do you wear glasses? ☐ Yes ☐ No ☐ Not currently, but in past

Do you have prism in your glasses? ☐ Yes ☐ No

Do you wear contacts? ☐ Yes ☐ No ☐ No, but I want contacts

Have you ever been diagnosed with any of the following? (Circle those that apply)

Glaucoma	Cataracts	Macular Degeneration
Retinal tear/detachment	Diabetic Retinopathy	Dry Eye

Do you experience any of the following symptoms? (Circle those that apply)

Blurry vision	Complete loss of vision	Double vision
Loss of side vision	Tearing	Glare/light sensitivity
Sandy feeling of eye	Styes	Flashes or floaters
Eye pain	Eye redness	Eye itching

Other eye symptoms:

_____

Have any of your FAMILY MEMBERS been diagnosed with any of the following? (Circle those that apply)

Lazy Eye	Macular Degeneration	Eyes going out	Thyroid Disease
Stroke	Glaucoma	Arthritis	High Cholesterol
Blindness/low vision	Retinal Disease	Cancer	High Blood Pressure
Cataract	Eyes crossing in	Diabetes	Heart disease

Other conditions:

_____

☐ My family history is unknown (Check box if true)

Review of Systems

Are you currently having any of the following symptoms? (Circle those that apply)

Fatigue/Tiredness	Trouble chewing	Scalp tenderness
Fevers/Chills	Sinus congestion	Dry Mouth
Easy Bruising	Chronic cough	Trouble breathing laying flat
Headaches/migraines	Seasonal allergies/Runny nose	Trouble hearing
Constipation	Nausea/vomiting	Diarrhea
Difficulty urinating	Neuropathy/tingling of feet	Arthritis