

The Eye Site

in Copley

Federal regulations require that we confirm the identity of patients using insurance with a photo ID.
To help speed the processing of your claims, we appreciate you allowing us to make a copy of your insurance cards.

Name _____ **Today's Date** ____/____/____
Last First MI

Address: _____
Street Apt City State Zip

Preferred Name/Pronouns: _____ **Gender:** Male Female Other:

Date of birth ____/____/____ **SSN** ____-____-____

Home phone: _____ **Cell phone:** _____

Email Address: _____

Your Employer (or school) _____

Primary **Medical** Insurance: _____ Policy #/ID: _____

Primary **Vision** Insurance: _____ Policy #/ID: _____

If you are not the policy holder, please list the policy holder's full name and DOB, and address, and SS#:

Name: _____ DOB: ____/____/____

Address: _____ SS#: _____

Reason for today's visit (check all that apply):

- | | |
|-------------------------------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Need new glasses | <input type="checkbox"/> Eye discomfort |
| <input type="checkbox"/> Need more contact lenses | <input type="checkbox"/> Annual Exam |
| <input type="checkbox"/> Blurred vision with current prescription | <input type="checkbox"/> Other _____ |

Assignment, Release, and Acknowledgement

I authorize payments of benefits directly to The Eye Site for services rendered. I also authorize release of any medical information that may be required in determination of such benefits. I understand some services may require approval of my primary care physician for coverage and that if I do not obtain that approval I am financially liable for the services. I understand that my insurance carrier(s) may not cover some services and products and benefit information does not constitute approval for payment.

Deductibles and fees not paid by my insurance carrier will be my responsibility.

Signature of patient (or legal guardian) _____

Have you been diagnosed with any eye conditions or diseases? yes no. If yes, please list.

Do you have, or take medication for any of the following? Please check all that apply.

- | | | |
|---------------------------------------------------|-------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Ear/nose/throat problems | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Skin disorders |
| <input type="checkbox"/> Sinus congestion | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Serious headaches | <input type="checkbox"/> Artery disease | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Neurologic condition | <input type="checkbox"/> Asthma or COPD | <input type="checkbox"/> Blood disorder |
| <input type="checkbox"/> Anxiety/depression | <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Seasonal allergies |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Urinary problems | <input type="checkbox"/> Cancer |

Please list all medications you take, including eye drops _____

Are you allergic to any medications? yes no...If yes, please list: _____

Have you had any type of **eye surgery**? yes no

If yes, what surgery? _____

Alcohol consumption (check one): yes no occasional

Smoking status (check one): no use daily occasional previous smoker

Is there a history in your **family (parents, siblings, or children)** of any of the following? Check all that apply.

	Father	Mother	Brother	Sister	Son	Daughter
Diabetes						
High Blood Pressure						
Cancer						
Retinal Detachment						
Macular Degeneration						
Glaucoma						
Blindness						

Do you currently wear glasses? yes no **Do you wear contact lenses?** yes no

If you wear contact lenses, what is the brand? _____

Name and address of your primary care physician: _____