eyecarecenter
OF COLORADO SPRINGS, PC

Part 1: Patient Information

Date _____ Patient Name _____

Address _____

City _____ State _____ Zip _____

Sex ☐Male ☐Female Height:_____ Weight:_____

Birthdate _____ Age _____

Whom May We Thank for Referring You?

_____

Marital Status: _____

Patient SS#: _____

Occupation: _____

Employer:_____

Employer Address: _____

Employer Phone: _____

Spouse's Name: _____

Spouse's Birthdate:_____

Spouse's SS#: _____

Spouse's Occupation:_____

Spouse's Employer: _____

Preferred Language ☐English ☐ Spanish

Race ☐ American Indian or Alaska Native
☐Asian ☐Black or African American ☐Hispanic
☐Native Hawaiian/other pacific Islander ☐White

Ethnicity: ☐Native Hawaiian/other Pacific Islander
☐Not Hispanic or Latino ☐Hispanic or Latino

Part 2: Insurance

Medical Insurance Company:

_____

Policy Holder's Name: _____

Relationship to Patient: ☐Spouse ☐Parent ☐Other

Policy Holder's DOB: _____

Vision Insurance Company: _____

Policy Holder's Name: _____

Relationship to Patient: ☐Spouse ☐Parent ☐Other

Policy Holder's DOB: _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____and assign directly to Dr. _____ 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 the information necessary to secure the payment of benefits. I authorize the use of this signature on all the insurance submissions.

Responsible Party Signature :_____

Relationship _____

Date _____

Part 3: Phone Numbers

Home Phone _____Work Phone _____

Cell Phone_____

Best Number and Time to Call _____

EMERGENCY CONTACT *Specify someone who does not live in your household.*

Name _____Relationship_____
Home Phone _____

Part 4: Eye Health History

Name of Physician _____

Date of Last Visit _____

Date of Last Eye Exam_____

Name of Doctor_____

Do you wear glasses? ☐Yes ☐No

How frequently?

Do you wear contacts? ☐Yes ☐No

What type of contacts? _____

Hour's per day? _____

Describe problems you have with contacts_____

PLEASE MARK "YES" OR "NO" TO INDICATE IF YOU HAVE ANY OF THE FOLLOWING:

Bloodshot Eyes	☐Yes	☐No	Dry Eyes	☐Yes	☐No	Loss of Vision	☐Yes	☐No
Blurred Vision – Distance	☐Yes	☐No	Eye Infection	☐Yes	☐No	Migraine Headaches	☐Yes	☐No
Blurred Vision – Near	☐Yes	☐No	Eye Injury	☐Yes	☐No	Night Vision, Poor	☐Yes	☐No
Burning Eyes	☐Yes	☐No	Eye Strain	☐Yes	☐No	Red Eyes	☐Yes	☐No
Cataracts	☐Yes	☐No	Fainting Spells, Blackouts	☐Yes	☐No	Seeing Halos	☐Yes	☐No
Color Vision, Poor	☐Yes	☐No	Floaters or Spots	☐Yes	☐No	Seeing Flashes	☐Yes	☐No
Crossed Eyes	☐Yes	☐No	Glaucoma	☐Yes	☐No	Temporary Loss of Vision	☐Yes	☐No
Discharge From Eyes	☐Yes	☐No	Headaches	☐Yes	☐No	Twitching Eyelid	☐Yes	☐No
Dizzy Spells	☐Yes	☐No	Itching Eyes	☐Yes	☐No	Poor Vision	☐Yes	☐No
Double Vision	☐Yes	☐No	Light Sensitive	☐Yes	☐No	Watering Eyes	☐Yes	☐No

PART 5: Medical History

Name of Physician_____ Date of Last Visit _____

PLEASE MARK "YES" OR "NO" TO INDICATE IF YOU HAVE ANY OF THE FOLLOWING. ALSO MARK IN THE APPROPRIATE COLUMN TO INDICATE IF A BLOOD RELATIVE HAS HAD ANY OF THE FOLLOWING PROBLEMS:

Condition	**Yourself**	**Blood Relatives**
AIDS/HIV	☐Yes ☐No	☐Yes ☐No
Arthritis	☐Yes ☐No	☐Yes ☐No
Artificial Heart Valve	☐Yes ☐No	☐Yes ☐No
Artificial Joints	☐Yes ☐No	☐Yes ☐No
Asthma	☐Yes ☐No	☐Yes ☐No
Blindness	☐Yes ☐No	☐Yes ☐No
Cancer	☐Yes ☐No	☐Yes ☐No
Cataracts	☐Yes ☐No	☐Yes ☐No
Chemical Dependency	☐Yes ☐No	☐Yes ☐No
Diabetes	☐Yes ☐No	☐Yes ☐No
Drug Sensitivity	☐Yes ☐No	☐Yes ☐No
Emphysema	☐Yes ☐No	☐Yes ☐No
Epilepsy	☐Yes ☐No	☐Yes ☐No
Glaucoma	☐Yes ☐No	☐Yes ☐No
Hay Fever	☐Yes ☐No	☐Yes ☐No
Heart Condition	☐Yes ☐No	☐Yes ☐No
High Blood Pressure	☐Yes ☐No	☐Yes ☐No
Lupus	☐Yes ☐No	☐Yes ☐No
Migraine Headaches	☐Yes ☐No	☐Yes ☐No
Pacemaker	☐Yes ☐No	☐Yes ☐No
Poor Color Vision	☐Yes ☐No	☐Yes ☐No
Retinal Disease	☐Yes ☐No	☐Yes ☐No
Rheumatic Fever	☐Yes ☐No	☐Yes ☐No
Shingles	☐Yes ☐No	☐Yes ☐No
Skin Conditions	☐Yes ☐No	☐Yes ☐No
Stroke	☐Yes ☐No	☐Yes ☐No
Thyroid Conditions	☐Yes ☐No	☐Yes ☐No
Tuberculosis	☐Yes ☐No	☐Yes ☐No
Turned Eye	☐Yes ☐No	☐Yes ☐No
Tobacco use	☐None ☐Former Smoker ☐Current Everyday Smoker ☐Current Someday Smoker	
Alcohol Use	☐None ☐Social Use Only ☐ 1-2 Drinks Daily ☐Above Average Use ☐Alcohol Dependence	

Are you Pregnant? ☐Yes ☐No Number of Children: _____

Medications

List medications you are currently taking, including eye drops:_____

_____

ALLERGIES *List your allergies to medications or other substances*_____

_____

Part 7: Acknowledgement of Privacy Practices

I acknowledge that I have received, read and understand the Notice of Privacy Practices containing a description of the uses and disclosures of my health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among multiple providers who may be involved in that treatment directly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that Eye Care Center of Colorado Springs, PC has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy.

Patient or Guardian Signature_____ Date_____

OFFICE USE ONLY
I attempted to obtain the patient's signature in acknowledgement but was unable to do so as documented below:

Date_____ Initials_____Reason_____

We are now making greater use of e-mail to communicate with our patients. To help us provide the most prompt service possible, Please enter your current e-mail address below

NOTE: All patient information is kept <u>strictly</u> confidential. Your address is NEVER shared.

If we have something important to tell you or we can't contact you otherwise, would you like a text message sent to our cellular phone? NO_____ YES_____ Cell Ph:_____