Shields Family Eyecare Center

Patient Name________________________ Today's Date______________ Birth Date_________
Marital Status_____________ Gender____________ Email_____________________________
Address ____
Street City State Zip
Cell Phone_____________ Work Phone________________ Employer____________________
Occupation___________________________

Primary Vision Insurance _________________ Primary Medical Insurance___________________
Policy Holder Name ______________________ Birthdate___________ SSN______________

Please allow receptionist to make a copy of your insurance cards

Date of last eye exam_______________
Do you wear eye glasses?______________ Do you wear contacts?________________
Would you like to discuss LASIK today?___________

Eye Health History

	Yes	*No*	*Family*		*Yes*	*No*	*Family*
Loss of Vision	____	____	____	Watering	____	____	____
Blurred Vision	____	____	____	Light Sensitive	____	____	____
Double Vision	____	____	____	Flashes/Floaters	____	____	____
Dryness	____	____	____	Eye Pain	____	____	____ ____
Redness	____	____	____	Night Glare	____	____	____
Itching	____	____	____	Discharge	____	____	____

Medical History (This information is kept strictly confidential).

Do you use tobacco products? ☐ Yes ☐ No Type/Amount ________________
Do you drink alcohol? ☐ Yes ☐ No Type/Amount ________________
Do you use medical marijuana? ☐ Yes ☐ No Type/Amount ________________

If none of the following apply check here_________

	You	Family		You	Family
Arthritis	_____	_____	Heart Disease	_____	_____
Asthma	_____	_____	HIV/Aids	_____	_____
Blindness	_____	_____	Lazy Eye	_____	_____
Cancer	_____	_____	Lupus	_____	_____
Cataracts	_____	_____	Macular Deg.	_____	_____
Cholesterol	_____	_____	Migraine	_____	_____
Diabetes	_____	_____	Retinal Disease	_____	_____
Glaucoma	_____	_____	Stroke	_____	_____
Hypertension	_____	_____	Thyroid Disease	_____	_____
Headaches	_____	_____	Turned Eye	_____	_____

Major surgeries or injuries:____
Allergies to Medications or Foods:____
Medications you are currently taking:_______________________________________

Assignment of Benefits: I request that payment of the assigned insurance be made directly to **Shields Family Eyecare** for any services rendered. I authorize **Shields Family Eyecare** to release my medical information to CMS and other agents to assess benefits payable for related services.

Signature_____________________________ Date___________________________