Welcome to our office!

PATIENT INFORMATION

Legal Name _____ Preferred Name _____

Birth Gender ☐ Male ☐ Female Race_____ Ethnicity _____

Date of Birth _____ Social Security Number _____

Address _____ City/State/Zip _____

Primary Phone # _____ Secondary Phone # _____
May we communicate with you via text including appointment reminders? ☐ Yes ☐ No

E-Mail Address _____ Communication Preference ☐ Phone ☐ Text ☐ E-mail
How did you hear about us? ☐ Insurance ☐ Google ☐ Facebook ☐ Friend/Family Referral ☐ Other _____

If referred, who may we thank for referring you to our office? _____

INSURANCE

Medical Insurance _____ Member ID # _____

Secondary Med. Insurance _____ Member ID # _____

Vision Insurance Provider _____ Member ID #_____

Responsible Party / Primary Insured Information-- If different from the patient

Name (as it appears on insurance card) _____

Date of Birth _____ Social Security Number _____

Address _____ State/Zip _____

Primary Phone # _____ Secondary Phone # _____

E-Mail Address _____ Relationship to Patient _____

PRIMARY CARE PHYSICIAN & PHARMACY

Physician Name_____ Clinic _____

☐ By checking this box I agree to have my records or diagnosis information shared with my physician.

Preferred Pharmacy _____ City & Crossroads _____

☐ By checking this box I agree to have my medications electronically imported from the pharmacy.

TELL US A BIT ABOUT YOURSELF

Do you currently wear glasses? ☐ Yes ☐ No

Have you ever worn contact lenses? ☐ Yes ☐ No

Do you currently wear contact lenses? ☐ Yes ☐ No

Brand/lens (if known) _____

How often do you replace? _____

Solution (if applicable) _____

Do you have any problems with your current glasses or contact lenses? ☐ Yes ☐ No

If yes, please explain _____

Are you interested in ☐ New glasses ☐ Sunglasses ☐ Contact Lenses ☐ Lasik ☐ Other

Special interests (hobbies, sports, occupational needs) _____

_____

We request that payment is due at time of service.
When ordering glasses or contacts, a minimum of half of the total is appreciated at time of purchase, and the other half may be paid prior to or during pick-up.

What is your preferred method of payment? ☐ Cash ☐ Check ☐ Credit/Debit Card

I request that payment of insurance benefits be made on my behalf to Tree City Eyecare for any services furnished to me by Tree City Eyecare. I authorize any holder of medical information about me to release to my insurance carrier and its agents any information needed to determine these benefits payable for related service.

I authorize and agree to pay for all services provided to me that are not covered by my insurance(s).

SIGNATURE _____ **DATE** _____

Please complete the following Medical History forms on the next few pages.

Are you currently experiencing any of the following?

- ☐ Blurred Far Vision
- ☐ Blurred Near Vision
- ☐ Redness
- ☐ Itching
- ☐ Tearing
- ☐ Burning
- ☐ Pain In/Around Eye
- ☐ Flashes of Light
- ☐ Floaters
- ☐ Headaches
- ☐ Double Vision
- ☐ Sensitivity to Light
- ☐ Head Trauma
- ☐ Computer Eye Strain
- ☐ Other _____

Have you ever been treated for or diagnosed with any of the following medical conditions?

- ☐ Allergies/Hay Fever
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Diabetes - I ☐ or II ☐
- ☐ Thyroid Disorder
- ☐ Stomach/Intestinal Problems
- ☐ Kidney/Urinary/Genital Disease
- ☐ MRSA/VRE
- ☐ Seizures/Epilepsy
- ☐ Ears/Nose/Throat Problems
- ☐ Blood Disorders/Prolonged Bleeding
- ☐ HIV/AIDS
- ☐ Skin/Acne/Rosacea
- ☐ Joint Pain/Arthritis
- ☐ Stroke/TIA
- ☐ Multiple Sclerosis
- ☐ Cancer
- ☐ Sleep Apnea
- ☐ Asthma
- ☐ Emphysema
- ☐ Smoker
- ☐ COPD
- ☐ Depression/Anxiety
- ☐ Heart Disease
- ☐ Migraines/Headaches
- ☐ Other _____ _____

Are you currently pregnant or nursing? ☐ Yes ☐ No

Have you had any non-eye-related surgeries? ☐ Yes ☐ No

Procedure _____ Date _____

Procedure _____ Date _____

Procedure _____ Date _____

Do you have any of the following eye conditions?

- ☐ Cataracts
- ☐ Glaucoma
- ☐ Detached Retina
- ☐ Dry Eyes
- ☐ Diabetic Retinopathy
- ☐ Macular Degeneration
- ☐ Crossed Eyes
- ☐ Keratoconus
- ☐ Lazy Eye
- ☐ Injury
- ☐ Other _____ _____

Have you ever had any eye surgery? ☐ Yes ☐ No

Procedure _____ Date _____

Surgeon and clinic _____

Procedure _____ Date _____

Surgeon and clinic _____

Procedure _____ Date _____

Surgeon and clinic _____

Current Medications

Medication _____ For _____ Dosage _____

Medication _____ For _____ Dosage _____

Medication _____ For _____ Dosage _____

Medication _____ For _____ Dosage _____

Other (attach list if necessary) _____

_____

Please list any drug sensitivities/allergies you have _____

_____

Other allergies _____

For Our Diabetic Patients

Most recent A1C value _____ When was it last tested? _____

Most recent fasting blood sugar value _____ When tested? _____

When was the last time you ate? _____ When were you diagnosed with diabetes? _____

Would you like us to send your Doctor a report on your visit today? ☐ Yes ☐ No

Diabetes care provider and clinic _____

Has anyone in your family (parents, grandparents, siblings) had any of the following?

- ☐ Blindness
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Keratoconus/Corneal Transplant
- ☐ Retinal Detachment
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Stroke
- ☐ Thyroid Abnormalities
- ☐ Diabetes
- ☐ Cancer
- ☐ Other _____

_____

☐ **I acknowledge that all the above information is truthful and accurate to the best of my understanding:**

Patient or Guardian signature _____ Date: _____

Office Use Only

□ Reviewed | Initials _____

Date: _____