

# Welcome To Carolina Eye Care

Please fill this form out in its entirety, the information that we gather is required by most insurance companies.

Thank You for Your Cooperation.

Name: \_\_\_\_\_  
Last First Middle Nickname or Preferred

Address: \_\_\_\_\_  
Street or PO Box City State Zip

Phone Numbers: Cell: \_\_\_\_\_ Home: \_\_\_\_\_ Email: \_\_\_\_\_  
Ok to Txt  Yes  No

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Gender  Male  Female  
Need to be able to file your insurance properly.

Race: \_\_\_\_\_ Ethnicity:  African American  Caucasian  Hispanic  Other Preferred Language:  English  Spanish  Other  
Some ethnic groups are more at risk for eye disease

Employer: \_\_\_\_\_ Employer Phone #: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

If Married, Spouse Name: \_\_\_\_\_ Spouse Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Emergency Contact Phone# \_\_\_\_\_

If under 18, parent or guardian's name: \_\_\_\_\_ Relation: \_\_\_\_\_

Why did you come to us? \_\_\_\_\_ Who may we thank for referring you? \_\_\_\_\_

Where does the rest of your family go for eye care? \_\_\_\_\_ # in household: \_\_\_\_\_

Do you plan on updating your glasses today?  Yes  No

## Insurance Information

Vision Insurance: \_\_\_\_\_ Insured Name: \_\_\_\_\_ Insured SS#: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Insured DOB: \_\_\_\_\_

Medical Insurance Name: \_\_\_\_\_ Insured Name: \_\_\_\_\_ Insured SS#: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Insured DOB: \_\_\_\_\_

## Billing Information & Privacy of you Medical Information

All co-payments, co-insurance, and deductibles are required at the time of service. Please be advised that your insurance benefits may not cover the services that you are receiving today (i.e. eye examination, glasses, contact lenses, or fundus photography).

The amount that you are paying for these services today **DOES NOT** include what we are billing to your insurance company on your behalf.

If you have **Medicare**, please be advised that **Medicare** DOES NOT cover ROUTINE EYE EXAMINATIONS, REFRACTIONS, or EYEWEAR.

By signing below, you understand that you may get a bill from Carolina Eye Care from the portion of your charges that your insurance company does not cover.

\_\_\_\_\_  
Patient and/or Guardian Signature

\_\_\_\_\_  
Date

# Medical History Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Last Medical Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_ Last Eye Exam \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Medical Doctor: \_\_\_\_\_ Dr.'s Phone: \_\_\_\_\_

## Medical History

Do you have any allergies to medications?  no  yes If yes, explain: \_\_\_\_\_

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

List all major injuries, surgeries and/or hospitalizations you have had:

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury? \_\_\_\_\_

Are you pregnant and/or nursing?  no  yes

Do you wear glasses?  no  yes

Do you wear contact lenses?  no  yes If yes, how old is your present pair of lenses? \_\_\_\_\_

Type of contact lenses:  Rigid  Soft  Extended Wear  Other Are they comfortable?  no  yes

## Family History

**Please note any family history (parents, grandparents, siblings and/or children, living or deceased) for the following medical conditions?**

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

## Social History

Do you drive?  no  yes If yes, do you have visual difficulty when driving?  no  yes If yes, please describe: \_\_\_\_\_

Do you use tobacco products?  no  yes If yes, type/amount/how long? \_\_\_\_\_

Do you drink alcohol?  no  yes If yes, type/amount/how long? \_\_\_\_\_

Do you use illegal drugs?  no  yes If yes, type/amount/how long? \_\_\_\_\_

Have you ever been exposed to or infected with:  Gonorrhea  Syphilis  HIV  Hepatitis

Review of Systems

Do you currently, or have you ever had any problems in the following areas: (If YES, please explain and list medications)

System	NO	YES	?	EXPLAIN / MEDICATIONS
INTEGUMENTARY (Skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
NEUROLOGIC				_____
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
EYES				_____
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Distorted Vision / Haloes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excess Tearing / Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glare / Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Flashes / Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
EARS, NOSE, MOUTH, THROAT				_____
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dry Throat / Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
RESPIRATORY				_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Brochitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
VASCULAR				_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
GASTROINTESTINAL				_____
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
GENITOURINARY (genitals / kidney / bladder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
BONES / JOINTS / MUSCLES				_____
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
LYMPHATIC / HEMATOLOGIC				_____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
ENDOCRINE (thyroid / other glands)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_\_  
Review Date