WELCOME TO MT. STERLING EYECARE

We are so pleased that you have entrusted your eye care to us. Please take a few moments to fill out the following information so that we may best meet your needs. Please print all information.

Patient Information

Name _____DOB_____Today's Date_____
(first) (middle initial) (last)

Preferred Name_____ SS #_____

Address _____
(street) (city) (state) (zip)

Email Address _____

Home Phone _____Cell Phone_____Work Phone _____

Do you prefer to receive calls at ____Home ____Cell ____Work Do you receive texts? Yes No

Patient Employer or School_____Occupation or Grade _____

Employer or School Address_____
(street) (city) (state) (zip)

Spouse or Parent's Name_____Employer_____Work Phone_____

Whom may we thank for referring you to us?_____

Responsible Party

Name of person responsible for this account_____

Relationship to patient_____Phone Number _____

Address_____
(street) (city) (state) (zip)

Employer_____Work Phone _____

Insurance Information

Name of Insured_____Relationship to Patient_____

Birthdate_____ Social Security Number_____ Date Employed_____

Name of Employer_____Work Phone _____

Vision Insurance Co._____Member ID _____Group #_____

Medical Insurance Co._____Member ID _____Group #_____

When making a third party claim, I authorize Mt. Sterling EyeCare to bill the insurance company on my behalf for any covered charges. I authorize the release of any medical information necessary for processing the claim. I also authorize my insurance company to pay Mt. Sterling EyeCare directly. I understand I am responsible for any amount not covered.

Patient or Parent Signature_____Date_____

Health and Vision History

Date of last vision exam_____Name of Eye Doctor_____
Do you currently wear glasses? Yes No
Do you currently wear contact lenses? Yes No If not, are you interested in contact lenses? Yes No

How much time per day do you spend in front of a computer or electronic device? _____ hours/day

Primary Care Physician _____ Address _____

PCP Phone Number _____PCP Fax Number _____

Are you currently receiving treatment from a physician? Yes No
(Women) Are you pregnant or nursing? Yes No
Are you presently taking or using any medication? Yes No If Yes, please list medications_____

_____

Do you use any of the following products:

Tobacco? Yes No Alcohol? Yes No Recreational Drugs? Yes No

Do you or any of your blood relatives have any of the following conditions?

	Self	Mother	Father	Sibling	No		Self	Mother	Father	Sibling	No
Diabetes	□	□	□	□	□	Glaucoma	□	□	□	□	□
Hypertension	□	□	□	□	□	Macular Degen	□	□	□	□	□
Thyroid	□	□	□	□	□	Retinal Detach	□	□	□	□	□
Heart Disease	□	□	□	□	□	Cataract	□	□	□	□	□
Cancer	□	□	□	□	□	Lazy eye/Eye turn	□	□	□	□	□

General Constitution			**Musculoskeletal**			**Eyes**		
Fever	Yes	No	Arthritis	Yes	No	Blurry vision	Yes	No
Weight loss	Yes	No	Joint pain	Yes	No	Double vision	Yes	No
Ear, Nose & Throat			Fibromyalgia	Yes	No	Glare/halos	Yes	No
Sinus issues	Yes	No	**Skin/Dermatological**			Eye irritation	Yes	No
Hearing loss	Yes	No	Rashes	Yes	No	Eye pain	Yes	No
Mouth/cold sores	Yes	No	Acne	Yes	No	Tired eyes	Yes	No
Cardiovascular Disease			**Neurological**			Crossed eyes	Yes	No
High Cholesterol	Yes	No	Headaches	Yes	No	Flashes of light	Yes	No
Stroke/CVA	Yes	No	Migraines	Yes	No	Floaters	Yes	No
Pulmonary			Seizures	Yes	No	Dry eyes	Yes	No
Asthma	Yes	No	Memory issues	Yes	No	Watery eyes	Yes	No
COPD	Yes	No	**Psychological**			Red eyes	Yes	No
Sleep Apnea	Yes	No	ADHD	Yes	No	Light sensitive	Yes	No
Genitourinary			Anxiety	Yes	No	Eye surgery	Yes	No
Kidney issues	Yes	No	Depression	Yes	No	Eye injury	Yes	No
Bladder issues	Yes	No	**Blood/Hematological**			**Other:**		
Gastrointestinal			Anemia	Yes	No			
Acid reflux	Yes	No	Bleeding/Clotting	Yes	No			
Endocrine			**Immunological**					

Hypothyroid	Yes	No	Drug allergies	Yes	No	
Hyperthyroid	Yes	No	Seasonal allergies	Yes	No	
Diabetes	Yes	No	Lupus/RA/Sjogren's	Yes	No	

Do you have problems with the following?