Capital Eye Center

PATIENT INFORMATION

PLEASE PRINT DATE_____

*** PATIENT'S FULL NAME**_____

Address_____

City _____ State _____Zip Code _____

Telephone _____ Birth Date _____ Age _____ Sex _____

Social Security No. _____Marital Status _____

Occupation _____Phone _____

Employed by _____

Employer's Address _____

In case of emergency contact: _____

Home telephone _____Work telephone _____

If patient is minor, name of person responsible for bill:

Name _____

Address _____

Home telephone _____Work telephone _____

INSURANCE INFORMATION (If applicable)

When completed, please give all insurance cards and Drivers license to receptionist for copying.

Primary Insurance _____Policy Holder's Name _____

Relationship to Patient _____Policy Holder's DOB _____

Policy No. _____Group No. _____

Secondary Insurance _____Policy Holder's Name _____

Relationship to Patient _____Policy Holder's DOB _____

Policy No. _____Group No. _____

Family or Referring Physician (first and last name) _____

* Insured or Authorized Person's Signature _____

* I authorize payment of medical benefits to the attending physician or supplier for services rendered. I also authorize the release of medical records to other authorized physicians or insurance companies as it pertains to my healthcare. I also understand that if my insurance plan does not cover the services provided, I will accept full financial responsibility for services incurred.

TODAY'S DATE_____ **REVIEWED:** _____

For Office Use

Have you ever been diagnosed with or treated for one or more of the follo\ving? If so. please indicate date of onset.

ASTHMA _____ HIGH BLOOD PRESSURE _____

ARTHRITIS _____ TUBERCULOSIS. HEPATITIS, HIV _____

CANCER _____ DIABETES _____

THYROID _____ HEART DISEASE _____

STROKE _____ CATARACTS _____

GLAUCOMA _____ MIGRAINES _____

SEIZURES _____ OTHER _____

Review of Symptoms **No Yes If YES, please explain**

Do you currently have any of the following problems:

Chronic fever, unexpected weight loss/gain, fatigue ..... ☐ ☐ _____

Ear/nose/throat problems (e.g., hearing loss, sinus problems, sore throat) ..... ☐ ☐ _____

Heart problems (e.g., chest pain, irregular heartbeat) ..... ☐ ☐ _____

Respiratory problems (e.g., shortness of breath, wheezing, coughing) ..... ☐ ☐ _____

Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea, vomiting) . ☐ ☐ _____

Urinary problems (e.g., pain or discomfort, blood in urine) ..... ☐ ☐ _____

Skin problems (e.g., rashes, excessive dryness) ..... ☐ ☐ _____

Musculskeletal probems (e.g., muscle aches, joint pain, swollen joints) ..... ☐ ☐ _____

Neurological problems (e.g., numbness, weakness, headaches, paralysis) ..... ☐ ☐ _____

Psychiatric problems (e.g., depression, anxiety) ..... ☐ ☐ _____

Family and Social History

Do any medical or eye diseases run in your family (e.g., diabetes, high blood pressure, cancer, glaucoma, macular degeneration)

☐ No ☐ Yes If YES, please explain _____

_____

Do you smoke? If yes, how much? ☐ Drink alcohol? If yes, how much? ☐

Capital Eye Center, Raleigh, NC