

LA GRANDE FAMILY EYE CARE

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1. Patient Information					
Last Name:		First Name:		Middle:	Date of Birth:
Parent/Guardian Name (Please Print):				Social Security #: XXX-XX-	
Street Address/PO Box:		City:	State:	Zip:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other			Home Phone:		Work Phone:
Occupation:		Employer:		Cell Phone:	Texting OK? <input type="checkbox"/> Yes <input type="checkbox"/> No
Why did you choose La Grande Family Eye Care? <input type="checkbox"/> Existing patient <input type="checkbox"/> Phone book <input type="checkbox"/> Internet <input type="checkbox"/> Insurance <input type="checkbox"/> Other <input type="checkbox"/> Referred by:				Email:	
Ethnicity: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Decline to Specify					

2. Insurance	
Vision	Medical
Insurance Co:	Insurance Co:
Insured ID#:	Insured ID#:
Insured Name (if different):	Insured Name (if different):
Insured D.O.B (if different):	Insured D.O.B (if different):
Insured Address (if different):	Insured Address (if different):
Insured Employer (if different):	Insured Employer (if different):
Assignment and Release: I assign directly to La Grande Family Eye Care all insurance benefits for services and products rendered. I understand I am financially responsible for all charges regardless of insurance benefits. I authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.	
Responsible Party Signature:	Date:

3. Medicare Authorization	
I authorize the release of any medical or other information necessary to process Medicare claims. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the physicians of La Grande Family Eye Care or suppliers of the services or materials provided through La Grande Family Eye Care.	
Signature of Beneficiary:	Date:

4. Privacy Practices	
I acknowledge that I had the opportunity to review the Notice of Privacy Practices for La Grande Family Eye Care.	
Patient/Guardian Signature:	Date:
Patient was given this notice but refused to sign. Staff signature:	Date:

5. Eye Health		
Reason for today's visit:		Date/Location last eye exam:
Do you wear glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had eye surgery?	
Do you wear contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Cataract <input type="checkbox"/> Other:	
If YES, what type of contacts:	<input type="checkbox"/> LASIK	
Are you currently experiencing any of the following with your eyes?		
<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Eye pain	<input type="checkbox"/> Dryness
<input type="checkbox"/> Loss of vision	<input type="checkbox"/> Itching	<input type="checkbox"/> Discharge
<input type="checkbox"/> Double vision	<input type="checkbox"/> Burning	<input type="checkbox"/> Light sensitivity
<input type="checkbox"/> Flashes/Floaters	<input type="checkbox"/> Redness	<input type="checkbox"/> Eye strain
Have you, or a family member, been diagnosed with any of the following?		
	You	Family Member
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Macular Degeneration	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

6. Systemic Health			
Primary care physician:		Last physical exam:	Pharmacy:
Height:	Weight:	Currently pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No	
Tobacco use? <input type="checkbox"/> Yes <input type="checkbox"/> No	Alcohol use? <input type="checkbox"/> Yes <input type="checkbox"/> No	Narcotic use? <input type="checkbox"/> Yes <input type="checkbox"/> No	
How much:	How much:	STD? <input type="checkbox"/> Yes <input type="checkbox"/> No	
List your current medications and reason for use , or provide us with a list:			
List any allergies you have including medication allergies:			
Do you currently, or have you ever had, any problems in the following areas?			
Cardiovascular	Ears, Nose, Mouth, Throat	Musculoskeletal	
Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing loss <input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No	
Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Muscle pain <input type="checkbox"/> Yes <input type="checkbox"/> No	
Constitutional	Hematological/Lymphatic	Neurological	
Fever <input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches/Migraines <input type="checkbox"/> Yes <input type="checkbox"/> No	
Weight Loss <input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	Numbness/Tingling <input type="checkbox"/> Yes <input type="checkbox"/> No	
Endocrine	Immunological	Psychiatric	
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles <input type="checkbox"/> Yes <input type="checkbox"/> No	Anxiety/Depression <input type="checkbox"/> Yes <input type="checkbox"/> No	
Thyroid <input type="checkbox"/> Yes <input type="checkbox"/> No	Sjogren's <input type="checkbox"/> Yes <input type="checkbox"/> No	Memory loss <input type="checkbox"/> Yes <input type="checkbox"/> No	
Gastrointestinal	Integumentary	Respiratory	
Nausea/Vomiting <input type="checkbox"/> Yes <input type="checkbox"/> No	Skin cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	
Diarrhea/Constipation <input type="checkbox"/> Yes <input type="checkbox"/> No	Dermatitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No	
Genitourinary		COPD <input type="checkbox"/> Yes <input type="checkbox"/> No	
Kidney disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Other condition not listed above:		
Prostate Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No			
Ovarian Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No			