EYECARE
Vision Center of Wauwatosa
Welcome to Our Office!

How did you choose our office?
☐ Friend or Relative ☐ Another Doctor
☐ Insurance List ☐ Saw Sign/Building
☐ Online Search. If so, where?_____
☐ Other: _____

Patient Information

Name _____ **Birth Date**_____/_____/_____
☐ Mr. ☐ Mrs. ☐Ms. | ☐ Male ☐ Female Social Security # _____
Address _____ **City** _____ **Zip**_____
Phone (please check the preferred contact method)
☐ Home _____ **☐ Cell** _____**☐ Ok to Text ☐ Work** _____

☐ Email Address_____ **Parent/Guardian Name** _____
(If under the age of 18)
Patient's Race _____ **Ethnicity** _____ **Preferred Language**_____
☐ Single ☐ Married ☐ Divorced ☐ Other
Primary Care Physician: _____
Employer/School: _____

Occupation: _____

Insurance Information

(a copy will be taken of your insurance card) **Major Medical** **Vision Plan**

Ins. Company _____ _____

Name of Policy Holder _____ _____

Relationship to Insured ___ Self ___ Spouse ___ Dependent ___ Self ___ Spouse ___ Dependent

Financial Policy

You must bring your insurance card to each visit. As a courtesy, we will bill your insurance for services rendered. However, we must have all insurance and referral information provided to us BEFORE services are rendered or full payment will be require before you leave. Questions involving eligibility, deductibles, co-payments, benefits and overall coverage must be addressed with your carrier, not our office. Not all insurance plans include vision care. **In cases of multiple vision/health plan coverage, medical tests will be billed to medical insurance; vision testing and devices will be billed to vision plans.** Anything not covered is the responsibility to the patient. You are responsible for any fees not covered by your plan or insurance. Accounts unpaid for 90 days are sent to collection. There is a $30 fee for returned checks. Patients are responsible for all costs associated with collection and/or legal actions.

I authorize Eye Care Vision Center of Wauwatosa to submit a claim to my insurance carrier and direct my insurance carrier to issue payment directly to the Eye Care Vision Center of Wauwatosa. I authorize the release of any medical information to my health plan.

I ACCEPT FULL RESPONSIBILITY FOR ALL CHARGES AND FEES RELATED TO MY MEDICAL TREATMENT AND VISION CORRECTION DEVICES.

Initial: _____

Notice of Privacy Practices Acknowledgment

In the course of providing services to you, we create, receive and store identifying health information. Is is often necessary to use and disclose this information in order to treat you, obtain payment of services, and to conduct healthcare operation involving our office. The "Notice of Privacy Practices" you have been given describes these uses and disclosures in detail.

☐ I acknowledge that I have been informed of The Notice of Privacy Practices. I acknowledge that I may request a copy of The Notice of Privacy Practices at any time.

☐ I DO authorize the release of prescription information to family members or the following persons:

Name(s) _____

or ☐ I do NOT authorize the release of prescription information / materials to family members.

I understand and have been provided with an opportunity to review the ***Notice of Privacy Policies*** that provides a more complete description of information uses and disclosures.

_____ _____
Patient / Guardian Signature Date

EYE CARE VISION CENTER OF WAUWATOSA

Patient/Family Health History

Patient Name: _____ Last Physical Exam: _____ /_____ Last Eye Exam: _____ /_____
Month / Year Month / Year

Do you have special visual requirements for computers, work (safety glasses), sports (fishing), driving (night) or hobbies? _____

_____

Please list all your current medications (include over the counter, vitamins and herbal therapy): _____

_____

List all major surgeries (including eye and laser surgery): _____

_____

List any allergic reactions to medications or eye drops: _____

_____

Do you wear: □ Eyeglasses □ Contact Lenses? Do you have a spare pair of glasses? □ Yes □ No Do you have sunglasses? □ Yes □ No

Do you use artificial tears? □ Yes □ No WOMEN - Are you pregnant? □ Yes □ No Are you breast feeding? □ Yes □ No

Please indicate if any of these eye or medical conditions apply to you or a family member (blood relatives only).

Family Member	You	Condition	Relationship
□	□	Blindness	_____
□	□	Cataract	_____
□	□	Eye Turn/Strabismus	_____
□	□	Glaucoma	_____
□	□	Keratoconus	_____
□	□	Lazy Eye/Amblyopia	_____
□	□	Macular Degeneration	_____
□	□	Retinal Detachment	_____
□	□	Retinal Disease	_____
□	□	Diabetes	_____
□	□	Headaches/Migraines	_____
□	□	Hypertension	_____
□	□	Cancer (Type _____)	_____
□	□	Other: _____	_____

Have you ever had:

□ Burning/Itching/Allergies □ ADD/ADHD
□ Crusty, Gritty Feeling □ Something in Eye
□ Double Vision □ Distortion of Vision
□ Droopy Eyelids □ Dyslexia
□ Dry Eyes □ Watery Eyes
□ Eye Ache or Pain □ Pink Eye/Red Eye
□ Flashes of Light □ Floaters
□ Glare/Halos Around Lights □ Light Sensitivity
□ Infection of the Eye or Lid □ Puffy Lids/ Sties
□ Loss of Vision in One Eye
□ Loss of Central/Side/Top/Bottom Vision
□ Mucous Discharge from Eye

When reading, do:
□ words run together? □ you lose your place easily?

Review of Systems: Please indicate below if you currently have or have ever had problems with the following conditions or symptoms:

Allergic/Immunologic
□ None □ Lupus □ Lyme Disease
□ Food Allergy □ Seasonal Allergy
□ Environmental Allergy
□ Rheumatoid Arthritis
□ Autoimmune Disorder /Sjogren's
□ Other _____

Ear, Nose and Throat
□ None
□ Sinusitis
□ Ringing in Ears/Tinnitus
□ Hearing Loss
□ Dry Mouth
□ Other _____

Gastrointestinal
□ None
□ IBD/Colitis/Crohn's
□ Acid Reflux/Ulcer
□ Liver Disease /Hepatitis
□ Other _____

Skin/Integumentary
□ None
□ Eczema /Psoriasis
□ Rosacea
□ Herpes Simplex
□ Herpes Zoster
□ Other _____

Psychiatric
□ None
□ Anxiety/Depression /Stress
□ Bi-Polar
□ Schizophrenia
□ Panic Episodes
□ Other _____

Cardiovascular
□ None □ Stroke □ Angina
□ High Blood Pressure
□ Heart Disease □ Heart Attack
□ High Cholesterol
□ Vascular Disease
□ Other _____

Endocrine/Glands
□ None
□ Diabetes
□ Thyroid Dysfunction
□ Other _____

Respiratory
□ None □ Tuberculosis
□ Asthma /Bronchitis
□ Sleep Apnea
□ COPD
□ Sarcoid
□ Other _____

Muscle/Skeletal
□ None
□ Arthritis
□ Fibromyalgia
□ Ankylosing Spondylitis
□ Joint/Muscle Pain
□ Other _____

Genital/Urinary
□ Kidney Disease
□ Prostate Disease
□ HIV Positive/AIDS
□ Herpes/Chlamydia
□ Other _____

Hematologic/Lymphatic
□ None
□ Anemia
□ Leukemia /Lymphoma
□ Bleeding or Blood Disorder
□ Bruise Easily
□ Other _____

Neurological
□ None □ Bell's Palsy
□ Multiple Sclerosis
□ Epilepsy
□ Tremors /Seizures/Blackouts
□ Migraine
□ Other _____

General Health
□ Rapid Weight Loss/ Gain
□ Fever /Chills
□ Fatigue
□ Cancer
□ Trauma

Social
□ Tobacco Use:
□ Current Smoker □ Former Smoker #/day_____
□ Recreational Drugs _____
□ Alcohol Consumption_____ oz./day_____
□ Exercise: □ Regularly □ Occasionally □ Rarely

Please sign below to acknowledge that this form is current:

Signature: _____ Date: _____ Reviewed by: _____