Welcome to Lilburn Eyecare & Optical Center

(Completion or update required at each patient appointment)

Today's Date____________

Patient Information

Last Name ______________________________ First Name _____________________ MI _______
Any nicknames or other names you would like to be called _________________________________
Address ____
City_____________________________________ State _________________ Zip ______________
Telephone (H) ____________________ (W) _______________________ (C) ________________
Which number would you prefer to be reached? ____
SSN______________________ Date of Birth_________________________ Gender: M F
Occupation_______________________________ Employer_________________________________
Spouse name of patient _______________________ Emergency Telephone ____________________
If a minor, guardian's name____________________ if a minor, guardian's SSN_________________
E-mail Address____

Date of last eye exam________________________ Were you dilated? __________________________
Where did you have your last exam? ____

General Health		If yes, Medication taken	Family History
High Blood Pressure	Yes No	___________________________	Yes No
High Cholesterol	Yes No	___________________________	Yes No
Heart Problems	Yes No	___________________________	Yes No
Diabetes	Yes No	___________________________	Yes No
Sickle Cell/other blood problems	Yes No	___________________________	Yes No
Allergy	Yes No	___________________________	Yes No
Respiratory Disorder	Yes No	___________________________	Yes No
Gastrointestinal Disorders	Yes No	___________________________	Yes No
Disorders of Ear, Nose or Throat	Yes No	___________________________	Yes No
Muscle or Bone Disorder	Yes No	___________________________	Yes No
Psychiatric Disorder	Yes No	___________________________	Yes No
Neurologic Disorder	Yes No	___________________________	Yes No
Genitourinary Disorder	Yes No	___________________________	Yes No
Skin Disorder	Yes No	. ___________________________	Yes No

Other Medical Conditions (if yes, explain) ____
____

Please answer all questions:
Medication Allergies____
Allergies Yes No Allergic to what? ____
Do you use tobacco? Yes No Alcohol? Yes No Other Substances? Yes No
Name of Family Doctor______________________________ Telephone_______________________

Eye Health History		**Family**	**Relation**
Macular Degeneration	Yes No	Yes No	___________________________
Retinal Detachment	Yes No	Yes No	___________________________
Glaucoma	Yes No	Yes No	___________________________
Cataracts	Yes No	Yes No	___________________________

List other eye surgeries or injuries____

Continue on the Back

Current Eye Problems

Blurry Vision	Yes	No	Dry Eyes	Yes	No
Double Vision	Yes	No	Sensitivity to Light	Yes	No
Flashes or Floaters	Yes	No	Redness	Yes	No
Burning, Itching	Yes	No	Night Vision	Yes	No
Headaches	Yes	No	Watery Eyes	Yes	No
Problems w/ glare	Yes	No	Swelling	Yes	No

Other Eye Problems ____

____

Do you wear Glasses? ____________ Type? _______________ Contact? ___________ Type? __________
Are you interested in Contacts? _____________ Are you interested in Laser Eye Surgery? _________________
Do work on the computer? _________________ If yes, how many hours a day? _________________________
What are your hobbies? ____

Insurance Information

Vision Insurance Name _____________________
Primary Member Insured_____________________
Primary Member SSN _______________________
Relationship _____________________________

Primary Medical Insurance _______________________
Primary Member Insured_________________________
Primary Member SSN ___________________________
Relationship __________________________________

Do you participate in a flex spending account? Yes No
How will you settle your account today? Cash Check Credit Card

Very Important for New Patients:
Has anyone in your family ever been seen in our office? If yes, who? _______________________________
Whom may we thank for referring you to us?
Yellow Pages Insurance Website Friend/Relative____________________________

ALL Patients must initial all that apply:
_______ I would like to have the Optomap retinal examination performed as a part of my exam today.
_______ I have received, read, and understand the office policies and agree to accept responsibility as described.
_______ I authorize the use of this signature block on all my insurance submissions.
_______ I understand that I am ultimately responsible for my bill.
_______ I have reviewed or received a copy of Lilburn Eyecare's Notice of Privacy Practices.
_______ All information is correct to the best to my knowledge.

____________________________________ ________________________
Patient or Guarantor Date

This is for the following years.
Second Year Review
_______ I have reviewed and updated any changes to this form.
_______ I would like to have the Optomap retinal examination performed as a part of my exam today.
Signature_____________________________ Date _____________________

Third Year Review
_______ I have reviewed and updated any changes to this form.
_______ I would like to have the Optomap retinal examination performed as a part of my exam today.
Signature_____________________________ Date _____________________

Please be aware next year we will require you to fill out a new form.