Welcome to Thomas Eye Care!

Please complete all the information below.

Today's Date: _____ Name: _____

Address: _____

City: _____ State: _____ Zip: _____Home Phone: _____

Cell Phone: _____Email Address: _____

Race: _____ Sex: _____ Marital Status (circle): Single, Married, Divorced, Widowed, Other.

Patient Social Security Number: _____ Date of Birth: _____

Employer (or School): _____Occupation (or grade): _____

Vision Insurance: _____ Medical Insurance: _____

Insured's Name: _____Insured's Employer: _____

Insured's SS#: _____

Name of primary physician: _____Last Medical Exam: _____

Reason for visit: _____

Previous Eye Doctor: _____ Last Eye Exam: _____

Please list any sports or hobbies: _____

Allergies to medication & reaction: _____

Medications: (If you have a list we would be happy to make a copy)

Please answer the following questions; Do you……

Work at the computer for long periods? Yes / No How many hours? _____

Spend a lot of time outside? Yes / No How many hours? _____

Have prescription sunglasses?

Have an interest in laser vision correction? Yes / No

Have you ever worn/ currently wear contact lenses? Yes / No

If yes, what kind of contact lenses? _____

Are you interested in contact lenses? Yes/ No

EYE HISTORY

Have you had or are you currently experiencing any of the following?

Circle yes or no:

Eye Injury Yes / No _____

Eye Surgery Yes / No _____

Eye Disease Yes / No_____

Lazy Eye Yes / No

Cataracts Yes / No

Glaucoma Yes / No

Itching Yes / No

Soreness Yes / No

Tearing Yes / No

Dryness Yes / No

Eyestrain Yes / No

Glare Yes / No

Flashes of Light Yes/ No

Headaches Yes / No

Redness Yes / No

Double Vision Yes / No

Blurry Near Yes / No

Blurry Distance Yes / No

Burning Yes / No

Sensitivity to light Yes / No

Gritty feeling in eye Yes / No

Floaters Yes / No

Poor Night Vision Yes / No

Family Medical History: Self or Family/Relationship

Blindness No Yes _____

Cataracts No Yes _____

Glaucoma No Yes _____

Diabetes No Yes _____

Heart Disease No Yes _____

High Blood Pressure No Yes _____

Macular Degeneration No Yes_____

Muscle Imbalance No Yes _____

Cancer No Yes _____

Cholesterol No Yes _____

Kidney Disease No Yes _____

Stroke No Yes _____

<u>Social History</u> (please circle)

Never Smoked

Former Smoker, how long ago? _____.

Current Smoker _____PPD _____Yrs.

Alcohol use, amount_____, how often_____.

Recreational drug use_____.

<u>Patient Medical History:</u>

Please indicate if you are currently experiencing problems/ symptoms in the following areas.

Yes No

____ ____ Constitutional (Fever, weight loss/gain, fatigue)

____ ____ Ear /nose /throat/mouth/dental. (Ulcers, infections, hearing loss)

____ ____ Cardiovascular. (Heart attack, high cholesterol, high blood pressure, stroke)

____ ____ Respiratory (Cough, shortness of breath, asthma, COPD)

____ ____ Neurological (Vertigo, tingling, numbness, headache, seizures)

____ ____ Musculoskeletal (Weakness, joint pain, back pain, arthritis)

____ ____ Endocrine (Thyroid disorders, diabetes)

____ ____ Hematological/ Lymphatic (Anemia, leukemia, blood disorders)

____ ____ Allergic/ Immunology (HIV, immune disorder, seasonal allergies)

____ ____ Genitourinary (Kidney stone, dysfunction)

____ ____ Psychiatric (Depression, anxiety, attention disorder)

____ ____ Integumentary (Psoriasis, eczema)

Patient/ Parent Signature_____Date_____

Thank you for choosing our practice to provide your eye care…..

We are committed to providing high quality care for our patients. Our goal is to help you reach the best optical healthcare possible.

Insurance

Your insurance coverage is a contract between you, your employer, and your insurance company. As a courtesy to our patients, we are happy to submit your claims for services. In order for us to do this, you must provide us with accurate and up-to-date insurance information. We will verify your coverage and plan before your appointment. With this, we will estimate the insurance portion and your co-payment. This may or may not be what the insurance will actually pay. Your plan may base its dollar allowance on a usual and customary fee schedule which may not coincide with current fees in our area. We'll do our best to help you receive maximum benefits. We will wait 60 days for insurance claims to be paid. After 60 days if payment has not been made, you will be asked to pay the balance and seek reimbursement from your insurance company.

Payment Options

Payment is expected at the time of your services. If you have insurance, we will provide an estimate of your co-payment and collect your portion at the time of your appointment. We accept cash, checks, Visa, MasterCard, and Discover. We also offer Care Credit, a healthcare financing program that offers interest-free payment plans upon approval.

A late fee of 3.0% will be assessed monthly to accounts after 60 days. Any unpaid balance over 90 days will be considered delinquent and turned over to a collection agency. Fees may apply. Returned check fee is $ 35.00.

Minor Patients

Please plan to be present at appointments with your child under 18. If you cannot be there, please make prior arrangements with our staff. The parent or guardian accompanying the minor child is responsible for payment. In the case of a divorce, regardless of decree, the parent who brings the child and has signed the financial agreement is responsible to pay for the child's services. We are unable to bill separate parties; therefore parents can work out the details.

Appointment Changes

Your reserved time in our office is important. We understand that sometimes it is necessary to change your appointment, so we ask that you kindly give us a minimum of 24 hours' notice. Without this notice, we are unable to offer treatment to other patients that may have needed our care. If 2 or more appointments are broken in a 12 month period without notice, all future appointments will be canceled and patients will be place on a "priority list" for their next visits.

Patient/ Parent Signature_____**Date**_____