

BRIGHTON EYE CARE

Welcome to our office. Thank you for choosing us for your eye care. We look forward to caring for you and your eyes.

PATIENT'S NAME: _____ DATE OF BIRTH _____ TODAY'S DATE _____

MAILING ADDRESS: _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

SOCIAL SECURITY # _____ OCCUPATION: _____ COMPUTER HOURS/DAY _____

PATIENT'S HOBBIES _____ E-MAIL ADDRESS: _____

***It may be necessary to use drops that dilate (enlarge) the pupil. Most people are able to drive afterwards with the use of sunglasses. We provide sun protection for you if you do not have any with you. Your near vision will be blurry for several hours after the drops are instilled and the large pupils will persist for up to 6 hours for most people. The use of these drops provides a more thorough view into the interior of your eye.

PATIENT'S EYE HISTORY:

Circle all that apply

Serious eye injuries	N	Y
Eye surgeries	N	Y
Crossed / lazy eye / patching therapy	N	Y
Double vision	N	Y
Floaters (new, large, many)	N	Y
Lid droop	N	Y
Burning / gritty / itchy / dry eyes	N	Y
Eye pain	N	Y
Bell's Palsy	N	Y
Gray / black outs	N	Y
Contact lens intolerance	N	Y
Red eyes / infections	N	Y
Iritis	N	Y
<u>New</u> night driving problems	N	Y
Reading / computer problems	N	Y
Do you currently wear:		
Contact lenses	N	Y
Glasses	N	Y
First glasses at age _____		

PATIENT'S MEDICAL HISTORY

Do you currently have any problems in the following areas? If YES, please circle and provide additional information. If NO, please check here: _____

<p>General Constitutional: unusually tired unexplained weight loss or gain</p> <p>Cardiovascular: Stroke Heart Attack High / low blood pressure Cholesterol</p> <p>Respiratory: Shortness of breath Asthma COPD Poor circulation Apnea</p> <p>Females: Pregnant Nursing</p> <p>Muscles, Bones, Joints: Arthritis Fibromyalgia Rheumatoid arthritis</p>	<p>Skin: Eczema Melanoma Rosacea</p> <p>GI: Crohn's Disease Ulcers</p> <p>Psychiatric: Depression Other</p> <p>Neurological: Parkinson's Multiple Sclerosis Migrane</p> <p>Endocrine: Hyper / Hypo Thyroid Diabetes</p>	<p>Blood / Lymph: Bleeding Disorders History of blood loss Reynaud's</p> <p>Allergic / Immunologic: Seasonal Allergies Lupus</p> <p>Ear, Nose, Throat: Hearing loss Dry Mouth</p> <p>Kidney / Bladder: Transplant Cancer</p> <p>Cancer: (list below)</p> <p>Other:</p>
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PATIENT'S SOCIAL HISTORY: (Circle appropriate answer)

Marital Status: Single Married Divorced Widowed

Do you drive?: Yes No

Alcohol Use: •Never •Socially •1-2 drinks/day
•Above average •Alcohol Dependence

Tobacco Use: •Never •Quit smoking _____ years ago
•Currently _____ packs/day

MEDICATIONS: Yes No If yes, please list below:

ALLERGIES: Yes No If yes, please list below:

HAVE YOU EVER FAINTED? IF YES, WHAT WERE THE CIRCUMSTANCES?

FAMILY EYE HISTORY:

Glaucoma	N	Y
Macular Degeneration	N	Y
Cataracts younger than age 45	N	Y
Retinal Detachment	N	Y
Blindness	N	Y
Eye Turn / Lazy Eye	N	Y
Other _____		

FAMILY (parents/ siblings) MEDICAL HISTORY:

Cancer	N	Y
Heart Attack	N	Y
Stroke	N	Y
High Blood Pressure	N	Y
Thyroid Disorder	N	Y
Diabetes	N	Y
Migranes	N	Y
Other _____		

Brighton Eye Care

Financial Information and Authorization

Patient Name: _____

Employer: _____

Primary Care Physician: _____

Parent/Guardian (Person responsible for payment on account)

Name _____ Relationship: _____

Address (if different from patient's): _____

Parent/Guardian Social Security #: _____ Phone #: _____

Primary Insurance Policy Holder: _____ Date of Birth: _____

Secondary Insurance Policy Holder: _____ Date of Birth: _____

Employer (if not the patient): _____

Payment of Benefits and Responsible Party Statement

I authorize payment of benefits, as determined by my insurer, directly to my Physician. I also understand that I may still be responsible for any balance not paid by my insurance company or vision plan. As the responsible party, I agree that all charges that are not directly paid by my insurance company or vision plan will be my responsibility. I will be responsible for any attorney or collection fees incurred to collect an unpaid balance.

Responsible Party Signature: _____ Date: _____

Consent to Disclose Information

I understand that Brighton Eyecare may use or disclose information about me to bill or receive payment for medical services provided. These disclosures may include releasing information to my health insurance or vision plan, organization, employer, hospital, physician, dentist, pharmacist or entities involved in collecting amounts owed to us.

Responsible Party Signature: _____ Date: _____