CITRUS PARK EYECARE
For Vision. For Health. For Life.

WELCOME TO OUR OFFICE

Patient Information

Last ______________________________
First ________________ MI ____________
Street ______________________________
City ____________ State ______________
Zip Code ____________ Sex M F
Please Circle Mr Mrs Ms Miss Dr
Date of Birth ________________ Age ________
Patient's SSN ________________________
Home Phone __________________________
Work Phone __________________________
Cell Phone ___________________________
Email Address ________________________
Employer (or School) ___________________
Occupation (or Grade) __________________
Spouse (or Parent's Name) _______________
Spouse (or Parent's Work) _______________

What is the major purpose of this visit?

____

Any problems with your current contact lenses or glasses?

____

____

VERY IMPORTANT! NEW PATIENTS ONLY:
Who may we thank for referring you to our office?
Name of friend or relative ________________

If not referred, how did you choose our office?
- ❑ Another Dr.
- ❑ Insurance List
- ❑ Yellow Pages: Which directory? ___________
- ❑ Web Page: Which Web Site? ____________
- ❑ Other _______________________________

Citrus Park Eyecare is committed to providing comprehensive Eyecare of the highest quality to you, your family, and our community. We promise to thoroughly explain your eye health status and vision needs with emphasis on preventative care resulting in an enhanced quality of life. Our experienced staff is dedicated to providing this care in an atmosphere of compassion and respect. We will strive to exceed your expectations at a level of service and value, without reservation, to ensure you will return and recommend our office to others.

Insurance Information

Vision Insurance__________________________
Subscriber Name__________________________
Subscriber SSN________________________
Subscriber Birth Date______________________

Primary Medical Insurance__________________
Subscriber Name__________________________
Subscriber SSN________________________
Subscriber Birth Date______________________

I certify that I, and/or my dependent(s) have insurance coverage and assign direct payment to Citrus Park Eyecare. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions.

____
Patient Signature

Lifestyle Questions

Do you……(check box if your answer is yes)
- ❑..Work at a computer? How may hours per day?_____
- ❑..Think you might benefit from thinner, lighter lenses?
- ❑..Spend time outdoors? How much? ____Hrs/week
- ❑..Have prescription sunwear?
- ❑..Want information on Laser Vision Correction surgery?
- ❑..Have more than 1 pair of current Rx eyewear?
- ❑..Have children?
- ❑..Have family members in need of eyecare?
- ❑..Have backup glasses?
- ❑..Have troubles driving at night?
- ❑..Have glasses specific for sports?

Have you ever experienced, been diagnosed or treated for any of the following?
- ❑ Blurry Vision
- ❑ Cataracts
- ❑ Crossed eye/Eye turn
- ❑ Eye Infections
- ❑ Flash of light
- ❑ Glaucoma
- ❑ Headaches
- ❑ Itchiness
- ❑ Macular Degeneration
- ❑ Retinal Detachment
- ❑ Tearing
- ❑ Uncomfortable glasses
- ❑ Other eye disorders__________________
- ❑ Burning
- ❑ Corneal Abrasions
- ❑ Double Vision
- ❑ Eye Injury
- ❑ Floaters/Spots
- ❑ Grittiness
- ❑ Iritis/Uveitis
- ❑ Lazy Eye
- ❑ Occasional dryness
- ❑ Sunlight Sensitivity
- ❑ Trouble seeing at night

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Name of Family Physician________________________
City____
Date of Last Physical Check-up____________________

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)______________________________

Allergies to medications? ❑ Yes ❑ No
If so, what medications?__________________________

Have you had any surgeries? ❑ Yes ❑ No
Do you use cigarettes/tobacco, alcohol, or other substances? ❑ Yes ❑ No

Have you ever been diagnosed or treated for the following health problems?

- □ Allergies
- □ Blood/Lymph
- □ Cholesterol
- □ Digestive
- □ Endocrine
- □ Fevers
- □ Kidney
- □ Neurological
- □ Respiratory
- □ Thyroid
- □ Unusual weight losses/gains
- □ Arthritis
- □ Cancer
- □ Diabetes
- □ Ears/Nose/Throat
- □ Fatigue
- □ High Blood Pressure
- □ Muscle/Bone
- □ Psychological
- □ Sinus

Patient Eye History

Date of Last Eye Exam_____________________________
By Whom?______________________________________

Have you ever tried contact lenses? ❑ Yes ❑ No

Do you currently wear contact lenses? ❑ Yes ❑ No
What kind?_____________________________________
Solutions used_________________________________

Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No

Would you prefer clear contact lenses or colored contact lenses? ❑ Clear ❑ Colored

If you wear bifocals, do the lines or head tilting bother you? ❑ Yes ❑ No

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:
❑ No ❑ Yes (Please check boxes)

		Relationship (Mother's or Father's side)
Blindness	❑	________________
Cataracts	❑	________________
Corneal Problems	❑	________________
Diabetes	❑	________________
Glaucoma	❑	________________
Heart Disease	❑	________________
Lazy Eye	❑	________________
Macular Degeneration	❑	________________
Retinal Problems	❑	

HIPAA

I, ____________________________ have received and/or reviewed a copy of the **Notice of Privacy Practices**.
Patient Signature

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Citrus Park Eyecare for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

____ ____________________
Signature of beneficiary, Guardian, or Personal Representative Date