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

## WELCOME TO OUR OFFICE

Last	Patient Information			
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?  What is the major purpose of this visit?  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 the use Subsc.  Is unde charge the use of compassion and respect. We will strive to exceed your expectations at a level of service and value, without reservation, to ensure		Visio		
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Insurance	Information			
Vision Insurance				
Subscriber Name				
0 1 1 0001				
Subscriber Birth Date				
D: 14 !: 17				
Primary Medical Insurance_				
Subscriber Name				
Subscriber Birth Date	- All \$500 AT			
I certify that I, and/or my de	pendent(s) have insurance			
coverage and assign direct p	ayment to Citrus Park Eyecare.			
I understand that I am finance				
charges whether or not paid	by my insurance. I authorize			
the use of my signature on a	ll insurance submissions.			
Patient Signature				
Lifestyle	Questions			
Do you(check box if yo	Our answer is vas			
□Work at a computer? Ho				
☐ Work at a computer: The				
□Spend time outdoors? Ho				
<ul><li>□Have prescription sunwear?</li><li>□Want information on Laser Vision Correction surgery?</li></ul>				
☐Have more than 1 pair of				
□Have thore than 1 pair of □Have children?	current Kx eyewear?			
☐Have family members in	need of avecare?			
-	fieed of eyecare:			
☐Have backup glasses?	mich+9			
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	☐ Burning			
☐ Cataracts	☐ Corneal Abrasions			
☐ Crossed eye/Eye turn	☐ Double Vision			
☐ Eye Infections	☐ Eye Injury			
☐ Flash of light	☐ Floaters/Spots			
☐ Glaucoma	☐ Grittiness			
☐ Headaches	☐ Iritis/Uveitis			
☐ Itchiness	☐ Lazy Eye			
☐ Macular Degeneration	☐ Occasional dryness			
☐ Retinal Detachment	☐ Sunlight Sensitivity			
☐ Tearing	☐ Trouble seeing at night			
☐ Uncomfortable glasses	- House seeing at night			
☐ Other eye disorders				
- Onici cyc disorders				

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

Patient M	edical History	Pat	tient Eye History	
	Name of Family Physician		Date of Last Eye Exam	
Date of Last Physical Check	c-up			
CURRENT MEDICATIONS (Rx or Over the Counter) (List name of medications including eye drops, vitamins, & birth control pills)		Have you ever tried contact lenses? ☐ Yes ☐ No  Do you currently wear contact lenses? ☐ Yes ☐ No What kind?  Solutions used		
Allergies to medications?	☐ Yes ☐ No	Are you satisfied with contact lenses?	the vision and comfort of your  Yes No	
		Would you prefer clear lenses?	r contact lenses or colored contact  Clear  Colored	
Have you had any surgeries? Do you use cigarettes/tobacc substances?			o the lines or head tilting bother  Yes No	
Have you ever been diagnosed or treated for the		Family Medical/Ey	Family Medical/Eye History (Check all that apply)	
ollowing health problems?  □ Allergies □ Blood/Lymph □ Cholesterol □ Digestive □ Endocrine □ Fevers □ Kidney □ Neurological □ Respiratory □ Thyroid □ Unusual weight losses/g	☐ Arthritis ☐ Cancer ☐ Diabetes ☐ Ears/Nose/Throat ☐ Fatigue ☐ High Blood Pressure ☐ Muscle/Bone ☐ Psychological ☐ Sinus	Blindness Cataracts Corneal Problems Diabetes Glaucoma Heart Disease Lazy Eye Macular Degeneration Retinal Problems	al history of any of the following:  Yes (Please check boxes)  Relationship (Mother's or Father's side)	
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.				
of benefits for related service	rs.			

Date

Signature of beneficiary, Guardian, or Personal Representative