CROSSROADS EYE CARE ASSOCIATES, LTD

PATIENT INFORMATION

Name: _____ **Age** _____
Last First M.I.

Address _____
City _____ **State** _____ **Zip Code** _____
Home Phone _____ **Work Phone** _____ **Cell Phone** _____
Social Security # _____ **Birth Date**: Month_____ Day_____ Year_____
Sex: Male Female **Marital Status:** Married Single Widowed Divorced
Email Address: _____

Employer Name _____ **Occupation** _____
Employer Address _____
City _____ **State** _____ **Zip Code** _____

Primary Care Doctor _____ **Phone #** _____
Address _____

Referring Doctor _____ **Phone #** _____
Address _____

If the person responsible for the patient's charges is **NOT** the patient, please complete:
Responsible Party _____ Relationship _____
Responsible Party Address _____
City _____ State _____ Zip _____
Responsible Party Social Security # _____
Responsible Party Date of Birth: Month _____ Day _____ Year _____

Insurance Information: Check here if you do **NOT** have any medical insurance ☐ and go on to the next section. If you have insurance, please complete the section below that pertains to your type of insurance:

☐ Medicare Number and Letter _____

☐ Other Insurance or Health Plan
Name of Plan _____
Address _____
Policy Number _____
Policyholder's Name _____
Policyholder's Social Security # _____
Policyholder's Date of Birth _____

☐ Workman's Compensation – Please complete employer information above.

Do you have vision insurance coverage? _____ Insurance Carrier: _____

Why did you choose Crossroads Eye Care Associates, Ltd?
☐ Friend ☐ Doctor ☐ Newspaper Ad ☐ Yellow Pages ☐ Other _____

I authorize the release of any medical information necessary to process this claim and request payment of benefits. I acknowledge responsibility for payment of fees for all services rendered regardless of any insurance coverage. I accept responsibility for payment if my referral/authorization is denied.

Signature _____ **Date** _____

PAYMENT IS DUE AT TIME OF SERVICE

Please complete reverse side

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR MEDICAL STATUS & HISTORY:

1. Have you ever been treated for any medical conditions? (e.g., diabetes, high blood pressure, arthritis, etc.)
☐ Yes ☐ No If YES, please explain: _____

2. Have you ever had any eye disease? (e.g., glaucoma, cataract, wandering or "lazy" eye, retinal detachment, etc.)
☐ Yes ☐ No If YES, please explain: _____

3. Have you ever had any surgery?
☐ Yes ☐ No If YES, please provide date & reason: _____

4. Have you ever been hospitalized?
☐ Yes ☐ No If YES, please provide date & reason: _____

5. Do you take any medications?
☐ Yes ☐ No If YES, please list: _____

6. Do you have any drug or food allergies?
☐ Yes ☐ No If YES, please list: _____

REVIEW OF SYSTEMS Do you currently have any of the following problems? If YES, please explain:

Chronic fever, unexpected weight loss/gain, fatigue ☐Yes ☐ No _____

Ear/nose/throat problems (e.g., hearing loss, sinus problems, sore throat) ☐ Yes ☐ No _____

Heart problems (e.g., chest pain, irregular heart beat) ☐ Yes ☐ No _____

Respiratory problems (e.g., shortness of breath, wheezing, coughing) ☐ Yes ☐ No _____

Gastrointestinal problems (e.g., heartburn, abdominal pain, vomiting, diarrhea) ☐ Yes ☐ No _____

Urinary problems (e.g., pain or discomfort, blood in urine) ☐ Yes ☐ No _____

Skin problems (e.g., rashes, excessive dryness) ☐ Yes ☐ No _____

Musculoskeletal problems (e.g., muscle aches, joint pain, swollen joints) ☐ Yes ☐ No _____

Neurologic problems (e.g., numbness, weakness, headaches, paralysis) ☐ Yes ☐ No _____

Psychiatric problems (e.g., depression, anxiety) ☐ Yes ☐ No _____

FAMILY & SOCIAL HISTORY

Do any medical or eye disease run in your family? (e.g., diabetes, high blood pressure, cancer, glaucoma, macular degeneration)
□ Yes □ No If YES, please explain _____

Do you smoke? □ Yes □ No How much? _____ Drink alcohol? □ Yes □ No How much? _____
Employed? □ Yes □ No How many hours per week do you work? _____

_____
_____
_____

_____ _____
M.D. Signature Date