DATE:_____

ADVANCED EYE *Institute*

Please fill out the following information so we can better serve you.

Step 1 PATIENT REGISTRATION

Patient_____

Address_____

_____

City State Zip

Home Phone_____

Cell Phone_____

Email Address_____

Sex: M F Birthdate_____Age_____

Social Security #_____

Marital Status: Married Single Widowed Divorced

Employer_____

Occupation_____

Work Phone_____

Name of Relative or Neighbor NOT living with you

Name:_____

Phone_____

Step 2 PATIENT INSURANCE

Name of person policy is under?_____

Policy Holder Employer_____

Relationship to patient_____

Birthdate_____SS#_____

Insurance Company _____

Group Number_____

Is patient covered by additional insurance? Yes No

Insurance Authorization and Assignment

I HEREBY AUTHORIZE DR._____ TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE PHYSICIAN(S) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE (E.G. DEDUCTIBLE, CO-PAYMENTS, ETC)

Please Sign:_____

Step 3 MEDICAL HISTORY

Medications:

_____

_____

_____

_____

Drug Allergies:_____

Primary Care Doctor:_____

Previous Eye Doctor:_____

List Eye Surgeries:_____

Last Eye Exam:_____

Interested in Contact Lenses? Yes No

Dryness/Discomfort with Contact Lenses: Yes No

Interested in LASIK vision correction? Yes No

STAFF ONLY :

Medical Insurance

1._____

2._____

Vision Plan

- ☐ Always Care
- ☐ Avesis
- ☐ VCP
- ☐ VSP
- ☐ Spectera
- ☐ Blue Cross (Vision)
- ☐ No Vision Plan

Do you currently have or had the following conditions:

General Health:

- ☐ Heart Disease
- ☐ Hypertension
- ☐ Stroke
- ☐ Head Trauma
- ☐ Headaches
- ☐ Cancer
- ☐ Diabetes
- ☐ Thyroid
- ☐ Multiple Sclerosis
- ☐ Asthma
- ☐ Emphysema
- ☐ Anemia
- ☐ Depression
- ☐ STD (HIV, Herpes)
- ☐ Arthritis
- ☐ Rosacea

Eyes:

- ☐ Eye Infections
- ☐ Retinal Detachment
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Lazy Eye

Please note any family member with the following:

- ☐ Blindness
- ☐ Cataracts
- ☐ Lazy Eye
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Disease