Swiss Eye Care

WELCOME TO OUR OFFICE

Name: _____ (Last First MI)
Today's Date: _____

Social Security #: _____ (Per insurance requirement only)
Age: _____ Sex: □ M □ F

Street: _____
Date of Last Exam: _____

City: _____State: ____ Zip:_____
Date of Birth: _____

Home Phone: _____
Work /Cell Phone: _____

E-mail: _____
What is the major purpose of this visit? _____

May we correspond with you by e-mail? □ Yes □ No
_____

Employer (or School): _____
Spouse (or Parent's Name): _____

Occupation (or Grade): _____
Spouse (or Parent's Work Phone): _____

Vision Insurance: _____
Health Insurance: _____

Policyholder's Name _____
Policyholder's DOB _____
Policyholder's SSN or ID # _____

How did you hear about our office (circle one): insurance friend newspaper internet other:_____

Current medications(Rx or Over the Counter)

			Name of Medication
Antihistamines	□Yes	□No	_____
Diuretics (Water Pills)	□Yes	□No	_____
Blood Pressure Pills	□Yes	□No	_____
Oral Contraceptives	□Yes	□No	_____
Sleeping Tablets	□Yes	□No	_____
Eye Drops	□Yes	□No	_____
Other _____	□Yes	□No	_____

Family Medical History

			Relationship
Blindness	□Yes	□No	_____
Cataracts	□Yes	□No	_____
Glaucoma	□Yes	□No	_____
Macular Degeneration	□Yes	□No	_____
Diabetes	□Yes	□No	_____
Heart Disease	□Yes	□No	_____
Other _____	□Yes	□No	_____

Do you have any allergies, medication or other? If yes, please explain:_____
_____

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

□ Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive? □ Yes □ No If Yes, do you have visual difficulty when driving? □ Yes □ No If Yes, please describe: _____

Do you use tobacco products? □ Yes □ No If Yes, type/amount/how long: _____

Do you drink alcohol? □ Yes □ No if Yes, type/amount/how long: _____

Do you use illegal drugs? □ Yes □ No If Yes, type/amount/how long: _____

Have you ever been exposed to or infected with: □ Gonorrhea □ Hepatitis □ HIV □ Syphilis

Are you pregnant? □ Yes □ No. If Yes, how many months? _____

Are you currently breastfeeding? □ Yes □ No

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

System	Yes	No	??		Yes	No	??
Constitutional				**Ears, Nose, Mouth, Throat**			
Fever, Weight Loss/Gain	□	□	□	Allergies, Hay Fever	□	□	□
Integumentary (Skin)				Sinus Congestion	□	□	□
Neurological				Runny Nose	□	□	□
Headaches	□	□	□	Post Nasal Drip	□	□	□
Migraines	□	□	□	Chronic Cough	□	□	□
Seizures	□	□	□	Dry Throat/Mouth	□	□	□
Eyes				**Respiratory**			
Loss of Vision	□	□	□	Asthma	□	□	□
Blurred Vision	□	□	□	Chronic Bronchitis	□	□	□
Distorted Vision/Halos	□	□	□	Emphysema	□	□	□
Double Vision	□	□	□	**Vascular/Cardiovascular**			
Dryness	□	□	□	Diabetes	□	□	□
Mucous Discharge	□	□	□	Heart Pain	□	□	□
Redness	□	□	□	High Blood Pressure	□	□	□
Sandy or Gritty Feeling	□	□	□	Vascular Disease	□	□	□
Itching	□	□	□	**Gastrointestinal**			
Burning	□	□	□	Diarrhea	□	□	□
Foreign Body Sensation	□	□	□	Constipation	□	□	□
Excess Tearing/Watering	□	□	□	**Bones/Joints/Muscles**			
Glare/Light Sensitivity	□	□	□	Rheumatoid Arthritis	□	□	□
Eye Pain or Soreness	□	□	□	Muscle Pain	□	□	□
Chronic Infection of Eye	□	□	□	Joint Pain	□	□	□
Or Lid				**Lymphatic/Hematologic**			
Sties or Chalazion	□	□	□	Anemia	□	□	□
Tired Eyes	□	□	□	Bleeding Problems	□	□	□
Endocrine				**Allergic/Immunologic**	□	□	□
Thyroid/Other Glands	□	□	□	**Psychiatric**	□	□	□

If you answered YES to any of the above or have a condition not listed, please explain and list medications:

_____

_____

_____

I do hereby authorize release of any medical information necessary to process insurance claims, and accept personal responsibility for the payment of charge for services rendered.

I have read and understand the above. _____

SIGNATURE OF PATIENT AND/OR RESPONSIBLE PARTY

_____ _____
DOCTOR SIGNATURE DATE

Advance Beneficiary Notice (ABN)

- Vision insurance DOES NOT pay for all care, even those tests or procedures your Eyecare Provider may recommend based on his or her professional expertise.
- Swiss Eyecare will bill your medical insurance.

What You Need To Do Now:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions you may have after you finish reading.

Patient Information:

Patient Name: _____
Patient Date of Birth: _____
Date of Service: _____

Recommended Services	Description of Service
Anterior Segment Photos	To capture images on the front surface of the eye in or to diagnose and treat those diseases.
Fundus Photography	To capture images on the back of the eye in order to detect early retinal diseases such as Glaucoma and Macular Degeneration.
Specular Microscopy	To measure the endothetial layer of the cornea to ensure proper corneal health for patients that wear contact lenses and diagnose certain corneal diseases such as Gurtata and Funch's.
Visual Field	To check Blindspots to help diagnose early Glaucoma and other retinal diseases.

Patient Name:	Date:
Patient Signature:	Relationship:

Swiss Eye Care
2625 Old Denton Rd ste 548
Carrollton, Tx 75007

PATIENT AUTHORIZATION

I authorize any holder of medical records including Psychiatric, Alcohol, Drug Abuse and HIV/AIDS or other information about me to be released to the SSA or Health Care Financial Administrator or it's intermediaries or carrier, or any other insurance carrier, any information needed for this or a related claim. I permit a copy of the authorization to be used in place of the original, and request payment of the medical insurance benefit either to myself or to the medical party who accepts assignment.

I agree to be responsible for payment of service render

_____Date_____
Signature of Responsible Party

_____ _____ _____
Signature Date Relationship to Patient

**** If you have any insurance, we will be glad to help you file for any benefits to which you are entitled. However, it remains the responsibility of the individual patient to settle his/her account promptly.****

Acknowledgement of Receipt for HIPAA Compliancy

I acknowledge that I've received or read a copy of *Swiss Eye Care's* notice of Privacy Practices.

Patient's Name: _____

Signature _____ Date _____