PATIENT FORM

GENERAL INFORMATION

Last, First, MI, Preferred Name					
Street Address					
City, State, Zip					
Phone, Type					
Phone 2, Type					
Email					
Preferred Contact Method		*cell phone*	*email*	*text*	*other*
Patient Social Security Number					
Date of Birth					
Male/Female					
Occupation/Employer				*full –time*	*part-time*
Marital Status	*married*	*single*	*divorced*	*legally separated*	*widowed*
Language, Race, Ethnicity					
Emergency Contact Person and Phone					
How did you hear about us?					

INSURANCE INFORMATION

Vision Insurance			
Vision Insurance Member Name			
Vision Insurance Member ID#			
Vision Insurance Member Date of Birth			
Vision Insurance Member Phone Number			
Primary Medical Insurance			
Primary Member Name			
Insurance ID#			
Insurance Policy#/Group ID#			
Primary Member Date of Birth			
Primary Member Social Security Number			
Primary Member Employer			
Your Relationship to Primary Member	*spouse*	*child*	*other(please explain)*
Secondary Medical Insurance			
Secondary Medical Insurance Member Name			
Secondary Medical Insurance ID#			
Secondary Medical Insurance Policy#/Group ID#			
Secondary Medical Insurance Member Date of Birth			
Secondary Medical Insurance Member Social Security Number			
Your Relationship to Secondary Medical Insurance Member			

Extended Payment Agreement and Advance Beneficiary Notice: By signing this form I hereby authorize the physician to release any information required to process this claim. I understand that I am financially responsible for non-covered services. I understand that any unpaid balances will be sent to collection and that I will be responsible for any and all collection costs, attorney fees, court costs, etc. I request that payment of authorized benefits, Medicare, or Medicaid be made to either me or on my behalf to Oxford Eye Clinic, for any services furnished to me by their providers. I understand that Medicare will only cover 80% of services rendered. I understand that Medicare does not cover the refraction portion of the exam ($30). I understand that Medicare does not cover glasses. I understand that Medicare only covers medical diagnosis and that routine vision is not covered.

Patient Signature or Authorized Representative: _____

Date: _____ / _____ / _____

PATIENT FORM

EYE HISTORY

Date of Last Eye Exam

Currently Wear Glasses?

Currently Wear Contacts?

Reason for today's visit

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

Cataracts	*Yes*	*No*	*Family*
Crossed Eye	*Yes*	*No*	*Family*
Glaucoma	*Yes*	*No*	*Family*
LASIK or RK	*Yes*	*No*	*Family*
Lazy Eye	*Yes*	*No*	*Family*
Macular Degeneration	*Yes*	*No*	*Family*
Retinal Detachment	*Yes*	*No*	*Family*

Are you currently experiencing, or have experienced any of the following? Check all that apply.

- ☐ Blurry Vision *Near or distance*
- ☐ Burning
- ☐ Discharge
- ☐ Dryness
- ☐ Excess Tearing/Watering
- ☐ Eye Infection
- ☐ Eye Pain or Soreness
- ☐ Floaters or Spots
- ☐ Halos
- ☐ Headaches
- ☐ Itching
- ☐ Light Flashes
- ☐ Light Sensitivity
- ☐ Redness
- ☐ Sandy or Gritty Feeling

MEDICAL HISTORY

Primary Care Provider

Have you or a family member experienced, or been treated for any of the following? Circle all that apply.

AIDS/HIV	*Yes*	*No*	*Family*
Allergies	*Yes*	*No*	*Family*
Arthritis	Yes	*No*	*Family*
Asthma	*Yes*	*No*	*Family*
Blood/lymph disorder	*Yes*	*No*	*Family*
Cancer	*Yes*	*No*	*Family*
Diabetes	*Yes*	*No*	*Family*
Ears, Nose, Throat	*Yes*	*No*	*Family*
Gastrointestinal	*Yes*	*No*	*Family*
Heart Disease	*Yes*	*No*	*Family*
High Blood Pressure	*Yes*	*No*	*Family*
High Cholesterol	*Yes*	*No*	*Family*
Kidney Disease	*Yes*	*No*	*Family*
Lupus	*Yes*	*No*	*Family*
Neurological Conditions	*Yes*	*No*	*Family*
Psychiatric Disorder	*Yes*	*No*	*Family*
Seizures	*Yes*	*No*	*Family*
Skin Conditions	*Yes*	*No*	*Family*
Stroke	*Yes*	*No*	*Family*
Thyroid Dysfunction	*Yes*	*No*	*Family*

Current Medications
(prescription and over-the-counter and dosage)

Medication Drug Allergies

Height **Weight**
Are you pregnant or nursing?
Do you smoke?
Have you ever smoked?

My information may be released to the following individuals:

Name: _____ Relationship: _____ Contact Number: _____
Name: _____ Relationship: _____ Contact Number: _____

I agree to and accept the Notice of Privacy Practices located by the front desk of Oxford Eye Clinic. I understand that I may receive my own copy upon request.

Patient Signature or Authorized Representative: _____
Date: _____ / _____ / _____