

Date \_\_\_/\_\_\_/\_\_\_

# LAKESHORE EYECARE CENTER PATIENT HISTORY FORM

(must update at each visit)

Name \_\_\_\_\_ Birthdate \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Male \_\_\_ Female \_\_\_ E-Mail \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_

Insurance listing  Family member  Yellow pages  Physician/Eye Doctor  Friend

Phone # Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Person Responsible for Payment \_\_\_\_\_ Relationship \_\_\_\_\_

Vision Insurance: ASR BCBS EBS MCD EYEMED SISCO HERITAGE VSP \_\_\_\_\_

Medical Insurance: ASR BCBS MEDICARE PRIORITY HEALTH \_\_\_\_\_

===== **STOP HERE - DO NOT WRITE BELOW THIS LINE** =====

## PERSONAL EYE-VISION INFORMATION

Have you had any serious eye injuries/surgeries? N Y \_\_\_\_\_

Other eye/vision issues: \_\_\_\_\_

At what age did you first begin to wear glasses? \_\_\_\_\_ Years old

What are your special vision activities: Reading, Computer, Hobbies, Outdoors,

## PERSONAL MEDICAL INFORMATION

Body Systems Review: Primary Care Doctor \_\_\_\_\_ Where \_\_\_\_\_

Ear/Nose/Throat N Y \_\_\_\_\_ Muscles/Joints N Y \_\_\_\_\_

Heart/Circulation/BP N Y \_\_\_\_\_ Skin Problems N Y \_\_\_\_\_

Lungs/Breathing N Y \_\_\_\_\_ Allergy N Y \_\_\_\_\_

Immunity N Y \_\_\_\_\_ Mental N Y \_\_\_\_\_

Digestive N Y \_\_\_\_\_ Neurological N Y \_\_\_\_\_

Constitutional N Y \_\_\_\_\_ Genitourinary N Y \_\_\_\_\_

Are you diabetic? N Y \_\_\_\_\_ Insulin Oral Year first diagnosed as diabetic? \_\_\_\_\_

List all medications you take: \_\_\_\_\_

Drug Allergies: N Y To What? \_\_\_\_\_

Have you ever experienced any serious head trauma? N Y \_\_\_\_\_

Do you use tobacco products? N Y Alcohol? N Y Other? \_\_\_\_\_

## FAMILY MEDICAL INFORMATION

Hypertension N Y \_\_\_\_\_ Glaucoma N Y \_\_\_\_\_

Diabetes N Y \_\_\_\_\_ Macular Degeneration N Y \_\_\_\_\_

Stroke N Y \_\_\_\_\_ Strabismus/Lazy Eye N Y \_\_\_\_\_

Thyroid N Y \_\_\_\_\_ "Strong Glasses" N Y \_\_\_\_\_

Rev'd \_\_\_\_\_

# LAKESHORE EYECARE CENTER

## A Insurance Waiver

I fully understand that I am personally responsible for all fees for eyecare services and/or optical products purchased at Lakeshore Eyecare Center which are not covered by my vision plan, medical insurance, Medicare, Medicaid, or any other third party insurance plan. I also understand that if I am ineligible for insurance benefits due to insurance plan denial of coverage that I am responsible for full payment to Lakeshore Eyecare Center for rendered services and/or products.

## B Medical Release

I grant Lakeshore Eyecare Center the permission to release, upon my demand, my medical records to other healthcare providers or insurance companies to further enhance my eyecare well-being and for billing procedures.

## C Signature Document

By signing below, I give Lakeshore Eyecare Center permission to bill my insurance for eyecare services and/or products. This will serve as my record of a "Signature on File" that insurance companies require for claims processing via e-mail or online.

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

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