**EXPERT EYECARE EDINBURGH—Patient Information**  Date: \_\_\_\_\_\_\_\_\_\_\_\_

*Please* ***PRINT*** *when filling out this form.*

Name of patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First Middle initial Nickname (if any)

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_\_\_\_\_

Gender: (circle one) **Male Female** Home phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth: \_\_\_/\_\_\_/\_\_\_\_\_\_\_ Work phone: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ext: \_\_\_\_\_\_

Birth state: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s maiden name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social security number: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred method of contact: (circle one) home phone work phone cell phone email U.S. mail

Employer or school: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of emergency, contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I heard about *Expert Eyecare Edinburgh/EDINBURGH PLLC* from: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If an individual, may we use your name in thanking this person? □ Yes □ No

*I authorize Expert Eyecare Edinburgh/EDINBURGH PLLC, to release my patient records and other health care information identifying me to Medicare and to each of my insurance companies. Expert Eyecare Edinburgh/EDINBURGH PLLC may act as my agent to file claims and obtain payment from Medicare and my insurance companies for all goods and services provided by Expert Eyecare Edinburgh/EDINBURGH PLLC. I authorize Medicare and each of my insurance companies to make payment directly to Expert Eyecare Edinburgh/EDINBURGH PLLC. I UNDERSTAND AND AGREE THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT FOR ALL GOODS AND SERVICES PROVIDED BY EXPERT EYECARE EDINBURGH/EDINBURGH PLLC, REGARDLESS OF ANY INSURANCE THAT I MAY HAVE. If I do not pay Expert Eyecare Edinburgh/EDINBURGH PLLC, all amounts owed within 30 days of the date on Expert Eyecare Edinburgh/EDINBURGH PLLC’s statement mailed to me, I further agree to pay all reasonable costs and expenses in connection with the attempted collection of such amounts (including, without limitation, reasonable attorney’s fees, collection agency fees, court costs and all other collection costs and expenses). If the patient named above is a minor, I am making these authorizations and agreements as the person responsible for payment of all goods and services provided to such minor by Expert Eyecare Edinburgh/EDINBURGH PLLC.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of person responsible for payment Date

Some eye health conditions may be covered by your medical insurance.

**Medical** insurance: □ None □Aetna □Anthem □BC/BS □Cigna □Medicare □Other: \_\_\_\_\_\_\_\_

Policyholder Information:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_/\_\_\_/\_\_\_\_\_\_\_ SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_\_\_

ID number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If not the policyholder, relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vision** insurance: □None □Yes If yes, name of insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY QUESTIONNAIRE**

Name of patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last eye exam: \_\_\_/\_\_\_/\_\_\_\_\_\_

Name of medical doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last medical exam: \_\_\_/\_\_\_/\_\_\_\_\_\_

Doctor’s phone (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_ Name of medical office where you’re seen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all hobbies and/or sports: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours do you work on a computer at a time? □ 3 or less □ 4 to 7 □ 8 or more

**ARE YOU INTERESTED IN…**

□ Yes □No Contact lenses that are clean and fresh every day?

□Yes □No Contact lenses you could safely sleep in overnight?

□Yes □No Laser vision correction?

□Yes □No A non-surgical alternative to glasses or contacts?

**GLASSES AND CONTACT LENS STATUS**

□Yes □No Do you have glasses? How old are they? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Yes □No Do you have more than one pair of prescription glasses?

□Yes □No Do you have sun-sensitive lenses in your glasses or use clip-ons over your lenses?

□Yes □No Do you have prescription sunglasses?

□Yes □No Do you have computer glasses?

□Yes □No Do you have contact lenses? What type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What solution do you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Yes □No Do you have non-prescription sunglasses?

**EYE AND VISION PROBLEMS YOU’RE EXPERIENCING** (Check all that apply.)

Blurred vision □ Eye pain or soreness □

Loss of vision □ Foreign body sensation □

Double vision/eye turn □ Dry/sandy feeling □

Floaters/flashes in vision □ Redness □

Headaches/migraines □ Burning □

Problems with eye irritation when it’s windy □ Itching □

Problems with reading □ Eyelid irritation □

Problems when working on a computer □ Watery eyes/excess tearing □

Problems when watching TV □ Mucous-like/filmy discharge □

Problems with night driving □ Contact lens discomfort □

Problems when playing golf or other sports □ Glare/light sensitivity □

Problems with eye fatigue □

**SOCIAL HISTORY** □*Yes, I would prefer to discuss my social history directly with my doctor.*

I smoke… □None □<1 pack/day □1-2 packs/day □Former smoker (Quit \_\_\_\_\_\_\_\_\_\_)

I drink… □None □Only socially □1-2 drinks daily □>2 drinks daily

Do you use illegal drugs? □No □Yes If yes, type/amount/how long \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL CONDITIONS** (Check all that apply.)

**Constitutional Integumentary/Skin**

Fever, weight loss/gain □ Acne rosacea □

Chronic fatigue □ **Neurological**

**Cardiovascular** Bell’s palsy □

Arteriosclerosis □ Headaches/migraines □

Cardiovascular disease □ Seizures □

Elevated cholesterol □ **Psychiatric**

Hypertension □ Attention deficit disorder (ADD) □

Stroke □ Depression □

**Facial/Cranial Endocrine**

Chronic sinusitis □ Crohn’s disease □

Dry mouth □ Diabetes □

**Respiratory** Gout □

Asthma □ **Hematologic/Lymphatic**

**Gastrointestinal** Anemia □

Chronic constipation □ **Immunologic**

Chronic diarrhea □ Histoplasmosis □

Hepatitis □ AIDS/HIV □

**Genitourinary** Herpes □

Kidney/bladder □ Molluscum contagiosum □

Ovarian/prostate □ Sjogren’s syndrome □

**Musculoskeletal**

Arthritis □ List all other conditions not checked above: \_\_\_\_\_\_\_\_\_\_\_\_

Muscle pain □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Myasthenia gravis □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all eye injuries or surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all EYE medications you take: (include over the counter) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all other medications you take: (include over the counter) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any drug allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any other allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY EYE HISTORY** FAMILY MEMBER WHO HAS LISTED CONDITION:

Cataracts □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Glaucoma □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lazy eye □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Macular degeneration □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Retinal detachment/disease □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY MEDICAL HISTORY**

Arthritis □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart disease □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High blood pressure □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thyroid disease □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RELEASE OF INFORMATION**

Listed below are the individuals that may pick up materials or receive information on my behalf:

1. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Last

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State

Phone number: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Last

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State

Phone number: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Last

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State

Phone number: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT**

I, (print name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, acknowledge that I received a copy of the Notice of Privacy Practices from Expert Eyecare Edinburgh/EDINBURGH PLLC.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of person responsible for payment Date

“Like” us on Facebook at **Expert Eyecare Edinburgh** to receive exclusive promotions and deals!

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Updated 8/28/2017