Name:_____ Date:_____

PLEASE FILL THIS FORM OUT COMPLETELY We may utilize electronic healthcare databases to retrieve information about your medications and health history.

PATIENT OCULAR HISTORY

Date of last eye exam:_____Where?:_____
Have you ever been diagnosed with any eye problems or eye diseases **besides** needing glasses? ☐ **Yes** ☐ **No**
If yes, please explain:_____
Eye Surgeries **Yes** ☐ **No** ☐ Types/Approx Dates:_____
Eye injuries **Yes** ☐ **No** ☐ Types/Approx Dates:_____
Wear glasses? **Yes** ☐ **No** ☐ When were they last updated?_____
Wear contact lenses? **Yes** ☐ **No** ☐ Type:_____Solution:_____
If not a current contact lens wearer, are you interested in wearing contact lenses? **Yes** ☐ **No** ☐
Do you plan to order new glasses today? **Yes** ☐ **No** ☐ **Only if necessary** ☐

PATIENT HEALTH HISTORY (Please mark all that apply

Eyes
☐ Eye Strain
☐ Blur
☐ Double Vision
☐ Dryness
☐ Watering/Matter
☐ Pain/Discomfort
☐ Itching
☐ Redness
☐ Floaters
☐ Flashing lights
☐ Lazy Eye
☐ Light Sensitive

Allergy/Immune
☐ Allergies
☐ Rheum Arthritis
☐ Sjogren's Syndrome
☐ Lupus
☐ HIV

Cardiovascular
☐ High Blood Pressure
☐ Heart Disease
☐ Stroke
☐ High Cholesterol

Endocrine
☐ Diabetic: Type I ☐ II ☐
Insulin ☐
Oral/Diet ☐
☐ Thyroid

GI
☐ Crohn's
☐ Colitis

Genitourinary
☐ Pregnant
☐ Breast Feeding
☐ Kidney Disease

Neurological
☐ Headache
☐ MS
☐ Seizure Disorder

Constitutional
☐ Devel disability
☐ Autism Spectrum

History of cancer? **Yes** **No** Type:_____ When_____

Family Doctor:_____Date of last visit:_____
List All Current Medications:_____
_____
_____
_____
_____
Medication Allergies/Reaction:_____
Environmental Allergies/Reaction:_____
Current Smoker ☐ Former Smoker ☐ Never a Smoker ☐

FAMILY OCULAR HISTORY Any relatives with these conditions? Check all that apply and indicate how related.

☐ Glaucoma_____
☐ Macular Degeneration_____
☐ Lazy Eye_____

SOCIAL HISTORY

Occupation:_____Currently a Student(grade/school):_____
Hobbies (sports, computers, reading, crafts/sewing, shooting sports, etc.):_____
_____

I acknowledge that I received (or declined) a copy of the Tipp Eye Center Notice of Privacy Practices (you may request a copy upon your arrival at our office). I also acknowledge that my current spectacle and contact lens prescriptions are available to me digitally via the Tipp Eye Center HIPAA compliant, secure patient portal at https://www.revolutionphr.com/

Signature:_____ Date:_____

Please complete the following information. Provide our receptionist with your medical and vision plan cards/info. Please send these cards with unaccompanied children for their exam.

Full Name_____M.I._____Preferred Nickname_____

Date of Birth_____ Social Security Number_____

Address_____

City_____ State_____ Zip_____

I **prefer** to be contacted by ☐Home Phone ☐Work Phone ☐Cell Phone (May we call you at work? ☐Yes ☐No)

Numbers: Home:_____ Work:_____ Cell:_____

Email: (Will be your Login for our Portal)_____

Insurance Company Names: Medical:_____Vision:_____

Emergency Contact Name:_____Phone:_____Relationship:_____

Primary Language: ☐ English ☐ Other:_____

Race: ☐White ☐ Black/African-American ☐ Pacific Islander ☐ Asian ☐ American Indian or Alaska Native ☐ Other

Ethnicity: ☐ Non-Hispanic/Latino ☐ Hispanic/Latino

INSURANCE POLICY HOLDER / INSURED IF NOT SELF

Name_____Relationship to patient (i.e. parent, spouse, etc.)_____

Street Address (if different than above)_____

City_____ State_____ Zip_____

Phone(if different from above)_____Social Security #_____

Date of Birth_____

Employer_____Work Phone_____

Who may we thank for referring you to our office?_____

Payment in full is expected at the time of service payable by cash, check, Visa, MasterCard, Discover, American Express or Care Credit. We will also gladly assist you in providing information to help expedite insurance carrier payments in order for you to be reimbursed.

SIGNATURE ON FILE: I request that payment of authorized Medicare or other insurance be made to Tipp Eye Center, Inc. I authorize the release of medical or other information necessary to process insurance claims on my behalf. I understand that my medical records are confidential. I understand that by signing this consent form I am allowing my medical information to be released upon my insurance company's request, to my insurance company for the purpose of Health Care Operations (including, but not limited to, provider review functions, claims payment and quality assessment). I also understand that I may revoke this consent by written request, at any time, with this doctor. If revoked, it is understood by all parties that all information released prior to being notified of such revocation was made with my consent. Additionally, I understand that if I revoke this release of information, my insurance cannot pay my claims without the information requested.

Signature:_____ Date:_____

PLEASE COMPLETE OTHER SIDE OF FORM AS WELL

PLEASE SILENCE CELL PHONES WHILE IN THE OFFICE. THANK YOU.