PATIENT INFORMATION

Date ______ Referred By ______ Birth date ______

Name (Last) ______ (First) ______ (MI) ______ Sex ______ Age ______

Address ______

City ______ State ______ Zip ______ Phone (H) ______

Employer ______ Occupation ______ Phone (C) ______

SS# ______ Spouse's Name ______ Family Physician ______

How did you hear about our office? ______

E-mail address: ______

Do you want ***appointment reminders*** by: Phone ______ E-mail ______ **(please check one)**

Insurance holder's information (Parent/Guardian/Guarantor Information)

Name ______ SS# ______ Birth date ______

Address (if different) ______

Phone (if different) ______

Employer ______ Occupation ______

Work Address ______ Work Phone ______

Insurance Information (Health and Vision Insurance)

Primary Insurance ______ Group # ______

Address ______ ID # ______

City ______ State ______ Zip ______ Phone # ______

Secondary Insurance ______ Group # ______

Address ______ ID # ______

City ______ State ______ Zip ______ Phone # ______

Patient Signature Form

I request that payment of authorized insurance and/or Medicare benefits be made either to me or on my behalf to Donald A. Bollheimer, M.D., Susan L. Eggebrecht, O.D., Eric. P. Purdy, M.D., or Zachary D. Roth, O.D. I further request that any supplemental insurance benefits be filed on my behalf be paid as stated above. I authorize any holder of medical information about me to release to my insurance and/or the Health care Financing Administration (HCFA) and its agent any information needed to determine these benefits or the benefits payable for related services. I (we) agree to pay my account, as services are rendered, i.e. co-payment, deductible, or percentage not covered by my insurance company. I (we) understand that responsibility for payment is mine (ours) due and payable at the time of service unless financial arrangements have been made. I (we) further understand that if my account is sent to collections/attorney I (we) promise to pay 18% annual interest and any court costs, and reasonable attorney's fees needed in order to collect the balance owed.

Patient/Parent signature ______________________ Date: ______________

Please answer the following questions about your medical status and history:

1. Have you ever been treated for any medical conditions? (e.g. diabetes, high blood pressure, arthritis etc.)
   Yes ____ No ____ If YES, please explain: ____________________
2. Have you ever had any eye disease? (e.g. glaucoma, cataract, wandering or "lazy" eye, retinal detachment)
   Yes ____ No ____ If YES, please explain: ____________________
3. Have you ever had any surgery?
   Yes ____ No ____ If YES, please provide date and reason: ____________________
   ____
4. Have you ever been hospitalized?
   Yes ____ No ____ If YES, please provide date and reason: ____________________
   ____
5. Do you have any drug or food allergies?
   Yes ____ No ____ If YES, please list: ____________________
   ____
6. Do you wear glasses? Yes No
7. Do you wear contact lenses? Yes No
8. Do you have difficulty seeing when driving? Yes No
9. Do you have a problem with night vision? Yes No
10. When was your last eye exam? ____________ By whom? ____________________

REVIEW OF SYSTEMS

Do you currently have any of the following problems?	**Yes**	**No**	**If YES, please explain:**
Chronic fever, unexpected weight loss/gain, fatigue	____	____	____________
Ear/nose/throat problems (e.g. hearing loss, sinus problems, sore throat)	____	____	____________
Heart problems (e.g. chest pain, irregular heart beat)	____	____	____________
Respiratory problems (e.g. shortness of breath, wheezing, coughing)	____	____	____________
Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea, vomiting)	____	____	____________
Urinary problems (e.g. pain or discomfort, blood in urine)	____	____	____________
Skin problems (e.g. rashes, excessive dryness)	____	____	____________
Musculoskeletal problems (e.g. muscle aches, joint pain, swollen joints)	____	____	____________
Neurologic problems (e.g. numbness, weakness, headaches, paralysis)	____	____	____________
Psychiatric problems (e.g. depression, anxiety)	____	____	____________

FAMILY AND SOCIAL HISTORY

Do any medical or eye diseases run in your family (e.g. diabetes, high blood pressure, cancer, glaucoma, macular degeneration)
Yes ____ No ____ **If YES, please list family member(s)** ____________________

____

Do you smoke? If yes, how much? ____________________

Do you drink alcohol? If yes, how much? ____________________