Welcome to Precision Eyecare

Today's Date:_____

Last:_____First_____MI____

Street_____

City _____State_____ Zip_____

Home Phone_____Work _____

Patient's DOB _____Patient's SSN _____

Employer_____

Occupation (or school) _____

Spouse (or parent's name) _____

Email Address_____

What is the major purpose of this visit? _____

_____

Any problems with your current contact lenses or glasses? _____

_____

Who may we thank for referring you to our office?

_____

If not referred, how did you choose our office for your needs?

☐ Insurance List ☐ Saw Sign/Building ☐ Newspaper

☐ Yellow Pages: Which directory? _____

☐ Webpage: Which website? _____

☐ Other: _____

Insurance Information

Vision Insurance: _____

Subscriber Name: _____

Subscriber SSN: _____Birth Date:_____

Medical Insurance: _____

Subscriber Name: _____

Subscriber SSN: _____Birth Date_____

The information in this confidential case history form is critical to the evaluation of your vision and health.

Have you been diagnosed or treated for the following:

☐ Cataract ☐ Iritis/Uveitis

☐ Corneal Abrasion ☐ Lazy Eye

☐ Eye Infection ☐ Macular Degeneration

☐ Eye Injury ☐ Retinal Detachment

☐ Glaucoma ☐ Other:_____

Family Medical/Eye History (Check all that apply)

Is there a family medical history of the following?

	Relationship
Blindness	☐_____
Cataracts	☐_____
Corneal Problems	☐_____
Glaucoma	☐_____
Lazy Eye	☐_____
Macular Degeneration	☐_____
Retinal Problems	☐_____
Diabetes	☐_____
Heart Disease	☐_____

Patient Medical History

Name of Family Physician_____

Town_____

Date of Last Physical Check Up_____

Current Medications (Rx or Over the Counter)

_____

_____

_____

Allergies to Medications ☐Yes ☐No

_____

Have you ever been diagnosed or treated for the following:

☐ Allergies ☐ Diabetes ☐ Thyroid

☐ Asthma ☐ Heart Disease ☐ Other_____

☐ Arthritis ☐ High Blood Pressure _____

☐ Cancer ☐ Kidney _____

☐ Cholesterol ☐ Nerves

Patient Eye History

Date of Last Eye Exam:_____

By whom? _____

Do you currently wear contact lenses ☐ Yes ☐ No

What kind? _____

Solutions used: _____

Have you tried Contact Lenses? ☐ Yes ☐ No

Do you experience or have you experienced?

☐ Blurry Vision	☐ Flash of light	☐ Burning
☐ Floaters/spots	☐ Crossed eye	☐ Grittiness
☐ Tearing	☐ Itchiness	☐ Double Vision
☐ Headaches	☐ Trouble seeing at night	
☐ Sunlight sensitivity	☐ Uncomfortable glasses	

Do you.....(Check box if your answer is yes)

☐ Work at a computer?

☐ Spend time outdoors? _____ Hours per week

☐ Have prescription sunglasses?

☐ Think you might benefit from thinner, lighter lenses?

If you wear bifocals do the lines or head tilting bother you?

☐ Yes ☐ No

If you wear contacts are you satisfied with the vision and comfort?

☐ Yes ☐ No

Cancellations

There will be a $20 rescheduling fee for **ALL** missed appointments. There will be no charge if you call us at least 2 hours before your scheduled appointment if you unable to keep it.

Insurance Coverage

As a courtesy, we will bill your insurance company for you. However, it is your responsibility to make sure your account is paid in full regardless of insurance payment.

Payment Policy

Payment in full is expected at the time of your appointment. We accept all major credit cards, personal checks and cash.

Returned Checks

There is a $25.00 service charge for all checks returned by the bank.

Receipt of Notice of Private Policies & Consent Form

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office

Assignment of Benefits

I authorize my insurance company to make payment directly to Dr. Daniel J. Morrill, of any benefits otherwise payable to me. I understand that I am responsible for any charges not paid by my insurance company within sixty days. Regardless of any insurance coverage, the total balance is the legal responsibility of the patient. A copy of this authorization shall be valid as the original.

Release of information: I _____hereby authorize Dr. Daniel J. Morrill of Precision Eyecare to furnish information concerning my care to my insurance company.

I have read and understand the above policies:

_____ _____

Signature Date