

PATIENT NAME: _____ DATE: _____

REVIEW OF SYSTEMS: _____

Do you presently have any problems in the following areas? If YES, please give an explanation:

		Yes	No	Explanation of problems			Yes	No	Explanation of problems
EYES:					LUNGS:				
Loss of vision	<input type="radio"/>	<input type="radio"/>	_____	Shortness of breath	.	<input type="radio"/>	<input type="radio"/>	_____
Distorted vision	<input type="radio"/>	<input type="radio"/>	_____	Respiratory problems		<input type="radio"/>	<input type="radio"/>	_____
Double vision	<input type="radio"/>	<input type="radio"/>	_____	Asthma	<input type="radio"/>	<input type="radio"/>	_____
Mucous discharge	..	<input type="radio"/>	<input type="radio"/>	_____	Other:	<input type="radio"/>	<input type="radio"/>	_____
Sandy feeling	<input type="radio"/>	<input type="radio"/>	_____	NEUROLOGICAL:				
Burning	<input type="radio"/>	<input type="radio"/>	_____	Strokes	<input type="radio"/>	<input type="radio"/>	_____
Excess tearing	<input type="radio"/>	<input type="radio"/>	_____	Headaches/migraines		<input type="radio"/>	<input type="radio"/>	_____
Glare/light sens.	...	<input type="radio"/>	<input type="radio"/>	_____	Other:	<input type="radio"/>	<input type="radio"/>	_____
Infect. of eye/lid	<input type="radio"/>	<input type="radio"/>	_____	ENDOCRINE:				
Fluctuating vision	...	<input type="radio"/>	<input type="radio"/>	_____	Diabetes Mellitus	...	<input type="radio"/>	<input type="radio"/>	_____
Blurred vision	<input type="radio"/>	<input type="radio"/>	_____	Thyroid	<input type="radio"/>	<input type="radio"/>	_____
Loss of side vision	..	<input type="radio"/>	<input type="radio"/>	_____	Other:	<input type="radio"/>	<input type="radio"/>	_____
Dryness	<input type="radio"/>	<input type="radio"/>	_____	ALLERGIC/IMMU:				
Redness	<input type="radio"/>	<input type="radio"/>	_____	Allergy symptom	...	<input type="radio"/>	<input type="radio"/>	_____
Itching	<input type="radio"/>	<input type="radio"/>	_____	Seasonal Allergy	...	<input type="radio"/>	<input type="radio"/>	_____
Eye Pain	<input type="radio"/>	<input type="radio"/>	_____	Other:	<input type="radio"/>	<input type="radio"/>	_____
Styes, chalazion	...	<input type="radio"/>	<input type="radio"/>	_____	GASTROINTESTINAL:				
Tired eyes	<input type="radio"/>	<input type="radio"/>	_____	Stomach /Intestines	.	<input type="radio"/>	<input type="radio"/>	_____
Glaucoma	<input type="radio"/>	<input type="radio"/>	_____	Other:	<input type="radio"/>	<input type="radio"/>	_____
Other	<input type="radio"/>	<input type="radio"/>	_____	CARDIOVASCULAR:				
EARS, NOSE, MOUTH, THROAT:					Hypertension	<input type="radio"/>	<input type="radio"/>	_____
Sinus congestion	...	<input type="radio"/>	<input type="radio"/>	_____	Heart/blood vess.	..	<input type="radio"/>	<input type="radio"/>	_____
Dry mouth/throat	...	<input type="radio"/>	<input type="radio"/>	_____	Other:	<input type="radio"/>	<input type="radio"/>	_____
Runny nose	<input type="radio"/>	<input type="radio"/>	_____	MUSCULOSKELETAL:				
Other	<input type="radio"/>	<input type="radio"/>	_____	Muscle pain	<input type="radio"/>	<input type="radio"/>	_____
HEMATOLOGICAL/LYMPHATICS:					Arthritis	<input type="radio"/>	<input type="radio"/>	_____
Anemia	<input type="radio"/>	<input type="radio"/>	_____	Multiple Sclerosis	..	<input type="radio"/>	<input type="radio"/>	_____
Leukemia	<input type="radio"/>	<input type="radio"/>	_____	Other:	<input type="radio"/>	<input type="radio"/>	_____
Other:	<input type="radio"/>	<input type="radio"/>	_____					

If patient is child: Pregnancy full term _____ If no, detail _____ Birth weight _____

Past Medical History: (Disease, illness or injury) ex: diabetes, high blood pressure: _____

List any surgeries you have had in the past:

List all medications you take including dosage and how often it is taken:

PLEASE BRING CURRENT MEDICATION, INCLUDING EYE DROPS WITH YOU!

Do you have allergies to any medications: _____ Yes _____ No

If YES, list medications:

SOCIAL HISTORY:

Do you drive? Yes No

Do you have difficulty when driving? Yes No

Do you have a problem with night vision? Yes No

Do you currently wear glasses? Yes No

If YES, how long have you had the current pair? . . . _____

Do you smoke? Yes No

If YES, how many packs a day? _____

FAMILY HISTORY:

DISEASES:

	Yes	No	Relationship to patient
Blindness	<input type="radio"/>	<input type="radio"/>	_____
Cataracts	<input type="radio"/>	<input type="radio"/>	_____
Glaucoma	<input type="radio"/>	<input type="radio"/>	_____
Macular degeneration	<input type="radio"/>	<input type="radio"/>	_____
Retinal detachment	<input type="radio"/>	<input type="radio"/>	_____
Eyes crossing, turning in or out	<input type="radio"/>	<input type="radio"/>	_____
Diabetes	<input type="radio"/>	<input type="radio"/>	_____
High blood pressure	<input type="radio"/>	<input type="radio"/>	_____
Heart disease	<input type="radio"/>	<input type="radio"/>	_____
Other	<input type="radio"/>	<input type="radio"/>	_____

PATIENT INFORMATION RECORD

Full Legal Name _____ Nickname _____

Home Address _____ Apt.# _____

City _____ State _____ Zip Code _____

Social Security Number _____ Home Phone _____ Cell Phone _____

Date of Birth _____ Age _____ Sex: Male Female Marital Status _____

Occupation _____ Employer _____ /or Retired From _____

Employer's Address _____ Business Phone _____

PRIMARY CARE DOCTOR _____ **ADDRESS** _____

EMERGENCY CONTACT (NOT LIVING WITH YOU:)Name _____ Phone _____ Relation _____

How were you referred to this office? _____

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Spouses Name _____ Social Security # _____

Date of Birth _____ Employer _____ Business Phone _____

Employer's Address _____

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If the patient is a minor the following information must be completed by Parent or Guardian:

Parent or Guardian's Legal Name _____

Father's Name _____ Mother's Name _____

Father's Address _____ Mother's Address _____

S.S. # _____ DOB _____ S.S. # _____ DOB _____

Home Phone _____ Work Phone _____ Home Phone _____ Work Phone _____

Employer _____ Employer _____

Address _____ Address _____

INSURANCE INFORMATION (*Insurance cards must be presented upon each visit*)

Were you injured at work? _____ Workman's Compensation Carrier _____

Are you enrolled in a Vision Care Plan? _____ **Name of Plan** _____

Identification # _____

Subscriber's Name _____ Date of Birth _____

Subscriber's Employer _____ SS# _____

Do you have health insurance? () No () Yes - if yes, indicate below

Primary Insurance Name _____ Identification # _____

Subscriber's Name _____ SS# _____

Date of Birth _____ Employer _____

Secondary Insurance Name _____ Identification # _____

Subscriber's Name if different _____

Date of Birth _____ Employer _____

I hereby authorize The Eye Group of Southern Indiana to treat my dependents or myself. I also authorize The Eye Group to furnish information to Insurance Carriers concerning my/their illness and treatments. This authorization is valid as long as I am a patient of The Eye Group. I understand that I am responsible for all financial obligations of health services for the above patient, and for reimbursement and payment of claims from my insurance company. If any unpaid balance is assigned for collection with a third party collection agency or placed with an attorney to obtain judgement or otherwise satisfy payment of my account, I agree to pay a collection fee of 33 1/3% of the unpaid balance. I further agree to pay reasonable attorney fees, court costs, interest, late fees and sheriff's fees. I understand and agree to the above terms. I have received a Notice of Privacy Practices from The Eye Group of Southern Indiana.

Signature of Patient or Responsible Party _____ Date _____

(OVER)

MEDICARE PATIENTS

As Medicare participating providers, **The Eye Group of Southern Indiana, LLC** accepts assignment on your insurance claims. Your signature is needed below so we may file your insurance accordingly.

Name of Beneficiary

Medicare Number

I request that payment of authorized Medicare benefits be made to me or on my behalf to **The Eye Group of Southern Indiana, LLC** for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the Health Care Finance Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient/Representative's Signature

Date

MEDIGAP BENEFITS

Name of Beneficiary

Medigap Policy Number

I request that payment of authorized Medicare benefits be made either to me or to **The Eye Group of Southern Indiana, LLC** on my behalf for any services rendered to me by that provider. I authorize any holder of medical information about me to release to the (Medigap Insurance Name) _____ any information to determine these benefits or the benefits payable for related services.

Patient/Representative's Signature

Date

MEDICAID PATIENTS

This is to acknowledge that I have been informed prior to my eye exam that Envision Optical is no longer a provider of optical goods and services for Indiana Medicaid patients.

Patient (or Guardian) Signature

Date

THE EYE GROUP

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 Evansville, IN 47710
 (812) 423-3131

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 (812) 423-3131

