SEE WELL EYECARE PATIENT INTAKE FORM

What is the main reason for your visit today?_____

Patient Name: _____ Preferred Phone: _____

Birthdate: _____/_____/_____ SSN: _____-_____-_____ Other Phone: _____

Address: _____ Email: _____

City: _____ State: _____ Zip: _____ Gender: _____

Guardian (if applicable) _____ Occupation: _____

How did you hear about us? _____ If referred, who may we thank? _____

Circle appropriate selection: Minor Single Married Divorced Widowed Separated

Race/Ethnicity: _____ Preferred Language: _____

Primary Care Physician/Office: _____ Date of last visit: _____

Pharmacy of Choice (including address): _____

Please check appropriate answers and fill in blanks:

	No	Yes	Unsure
Constitutional			
Fever, Weight Loss/Gain	☐	☐	☐
Cancer	☐	☐	☐
Ear, Nose, Mouth, Throat			
Dry Throat/Mouth	☐	☐	☐
Hearing Loss	☐	☐	☐
Neurological			
Seizures/Epilepsy	☐	☐	☐
Migraines	☐	☐	☐
Tumor	☐	☐	☐
Tension Headaches	☐	☐	☐
Multiple Sclerosis	☐	☐	☐
Psychiatric			
Anxiety/Depression	☐	☐	☐
Vascular/Cardiovascular			
Heart Disease	☐	☐	☐
High Blood Pressure	☐	☐	☐
Stroke	☐	☐	☐

	No	Yes	Unsure
Gastrointestinal			
Acid Reflux	☐	☐	☐
Crohn's Disease	☐	☐	☐
Ulcerative Colitis	☐	☐	☐
Bones/Joints/Muscles			
Muscle/Joint Pain	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐
Osteoarthritis	☐	☐	☐
Fibromyalgia	☐	☐	☐
Ankylosing Spondylitis	☐	☐	☐
Infectious Diseases			
Shingles/Herpes Zoster	☐	☐	☐
Herpes Simplex (HSV)	☐	☐	☐
HIV/Aids	☐	☐	☐
Syphilis	☐	☐	☐
Gonorrhea	☐	☐	☐
Hepatitis	☐	☐	☐
Chalamydia	☐	☐	☐

Respiratory

Asthma	☐	☐	☐
Sleep Apnea	☐	☐	☐
Emphysema	☐	☐	☐
Chronic Bronchitis	☐	☐	☐

Allergic/Immunologic

Seasonal Allergies	☐	☐	☐
Sjogren's Syndrome	☐	☐	☐
Lupus	☐	☐	☐

Genitourinary

Pregnant	☐	☐	☐
Nursing	☐	☐	☐
Prostate Disease	☐	☐	☐

Integumentary

Rosacea	☐	☐	☐
Other	☐	☐	☐

Endocrine

Type 1 Diabetes	☐	☐	☐
Type 2 Diabetes	☐	☐	☐
Thyroid Dysfunction	☐	☐	☐

If you have a condition not listed, please explain, and list any medications you are taking (include oral contraceptives, aspirin, over-the-counter medication, and home remedies):

_____

_____

_____

Do you have any allergies to medication? ☐ No ☐ Yes If yes, explain _____

_____

Ocular History:

	No	Yes	Unsure		No	Yes	Unsure
Loss of Vision	☐	☐	☐	Mucous Discharge	☐	☐	☐
Blurred Vision	☐	☐	☐	Redness	☐	☐	☐
Distorted Vision/Halos	☐	☐	☐	Sandy or Gritty Feeling	☐	☐	☐
Loss of Side Vision	☐	☐	☐	Itching	☐	☐	☐
Double Vision	☐	☐	☐	Burning	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐	Foreign Body Sensation	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐	Retinal Disease	☐	☐	☐
Chronic Infection of Eye or Lid	☐	☐	☐	Glaucoma	☐	☐	☐
Sties or Chalazion	☐	☐	☐	Cataract	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐	Amblyopia	☐	☐	☐
Excess Tearing/Watering	☐	☐	☐	Strabismus	☐	☐	☐
Dryness	☐	☐	☐	Eye Injury	☐	☐	☐
				Eye Surgery	☐	☐	☐

If you answered “Yes” to any of the above, or have a condition not listed, please provide an explanation and list any medications or drops you are using:_____

_____

Do you currently or have you ever worn contact lenses? ☐ No ☐ Yes If yes, which brand? _____

Family History:

Please note any family history (parents, grandparents, siblings, children - living or deceased) for the following conditions:

	No	Yes	Unsure	Relationship		No	Yes	Unsure	Relationship
Cancer	☐	☐	☐	_____	Cataract	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____	Macular Degeneration	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____	Glaucoma	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____	Strabismus	☐	☐	☐	_____
Heart Attack	☐	☐	☐	_____	Amblyopia	☐	☐	☐	_____
Stroke	☐	☐	☐	_____	Retinal Detachment	☐	☐	☐	_____

Social History – This information is kept strictly confidential.

Do you drive? ☐ No ☐ Yes If yes, do you have visual difficulty when driving? ☐ No ☐ Yes

If yes, please describe: _____

Do you drink alcohol? ☐ No ☐ Yes If yes, type/amount/how long_____

Do you use tobacco products? ☐ No ☐ Yes If yes, type/amount/how long _____

Do you use illegal drugs? ☐ No ☐ Yes If yes, type/amount/how long _____

Does the patient have any learning or behavioral disabilities? Please explain:

_____

Please Initial Each of the Following Sections:

_____ Payment Policy: By making an appointment at See Well Eyecare, you are agreeing to abide by all billing policies of our practice. Payment is required at the time services are rendered or materials are ordered. Quotes of insurance coverage are based on information from the insurance company and are not guaranteed. Although we will gladly bill insurance for you, the patient remains responsible for their charges even after the insurance has been billed. If payment has not been received from insurance after 60 days, the patient will be expected to pay See Well Eyecare directly.

_____ Financial Responsibility: I understand that I am personally responsible for payment of my account even if I have insurance. If it becomes necessary to use a collection agency for any amount owed on this or subsequent visits, the undersigned agrees to pay all costs and expenses including reasonable attorney's fees. Accounts assigned to collections may be charged a $40 collections fee.

_____ Cancellation Fee: A cancellation charge of $40 may be billed to you personally if you do not provide at least 24 hours' notice of a cancellation or change in your appointment date or time.

_____ No Show Fee: A no show charge of $40 may be billed to you personally if you do not show for your scheduled appointment.

_____I understand that three (3) repeated missed appointments or late cancellations may result in dismissal from the practice.

_____ Release of Information: I hereby authorize release of my information to my insurance company or to any health care professional or education professional when necessary for my health care billing. (This allows us to bill your insurance.)

_____ Privacy Policy: We respect our legal obligation to keep health information private. We are obligated by law to give you notice of our privacy practices. If you would like to receive a copy of our Notice of Privacy Practices, please request one from the receptionist today or at any time in the future. I understand that See Well Eyecare has a Notice of Privacy Practices available for my review if I wish. At the present time, I acknowledge that this notice has been offered and I accept the Notice of Privacy Practices.

_____ These policies will be enforced for both new patients and established patients. Our staff will be happy to answer any further questions regarding these policies.

Signed (Patient/Patient Representative): _____ Date: _____

Description of Representative's Authority:_____