Welcome

Please fill out this form completely. The better we communicate, the better we care for you.

Last Name: ________ First Name: ________ I prefer to be called: ________

Address: ________ City: ________ State: ________ Zip: ________

Home Phone: ________ Work Phone: ________ Cell Phone: ________

SS#: ________ Date of Birth: ________ E-mail: ________

Occupation: ________ Employer: ________

Emergency Contact: ________ Phone #: ________ Last Eye Exam: ________

Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Referred By: ________

Preferred Language: ________ Race: ________ Communication Preference: (e-mail , postal , phone , text)

INSURANCE INFORMATION

Insureds Name: ________ Insureds Date of Birth ________

Guarantor's Name: ________ Guarantor's Date of Birth: ________

Guarantor's Address: ________ City: ________ State: ________ Zip: ________

PERSONAL MEDICAL HISTORY

N Y Allergic / Immune (Seasonal, HIV, AIDS) Other: ________ Meds: ________

N Y Blood / Lymph (bleeding disorder, lymphoma) Other: ________ Meds: ________

N Y Cardiovascular (high blood pressure, cholesterol) Other: ________ Meds: ________

N Y Ear / Nose / Throat (Sinus) Other: ________ Meds: ________

N Y Endocrine (diabetes, thyroid disorder) Other: ________ Meds: ________

N Y Eyes (lazy eye, retinopathy, LASIK) Other: ________ Meds: ________

N Y Gastrointestinal (acid reflux, ulcers) Other: ________ Meds: ________

N Y Genital /Urinary (bladder cancer, prostate cancer) Other: ________ Meds: ________

N Y Mental (anxiety, depression, ADD, ADHD) Other: ________ Meds: ________

N Y Nervous (headaches, fibromyalgia) Other: ________ Meds: ________

N Y Respiratory (asthma, lung disease) Other: ________ Meds: ________

N Y Skin (acne, psoriasis) Other: ________ Meds: ________

List known allergies: ________

Name of Family Doctor: ________ Do you wear contacts? N Y Type: ________

Previous Eye Doctor: ________ Are you interested in contacts? N Y

Have you had any eye operations? N Y ________ Do you have questions about laser eye surgery N Y

MAIN REASON FOR VISIT: ________

FAMILY HISTORY INFORMATION

Cataracts N Y ________ Heart Disease N Y ________ Macular Degeneration N Y ________

Diabetes N Y ________ High Blood Pressure N Y ________ Poor Color Vision N Y ________

Glaucoma N Y ________ Lazy / Crossed Eye N Y ________ Retinal Disorder(s) N Y ________

Other eye condition(s) N Y *Type:* ________

INSURANCE ACKNOWLEDGEMENT

Please remember that most insurance companies do not cover your fees in full. You will be responsible for any deductibles, co-pays or non-covered items at the time of service. **RELEASE: I authorize SouthWest Eyecare to release any information required for insurance processing. I understand that I am responsible for all charges that my insurance company does not pay.**

Patient Signature (parent if minor): ________ Date: ________

PRIVACY ACKNOWLEDGEMENT

I acknowledge that I have been offered a copy of SouthWest Eyecare's Notice of Privacy Practices.

Patient Signature (parent if minor): ________ Date: ________

THANK YOU !