HEART OF AMERICA EYE CARE, P.A.

PLEASE COMPLETE THIS FORM. IT WILL BECOME PART OF YOUR PERMANENT RECORD

PATIENT INFORMATION

Patient's Name: Last		First	Middle	Maiden	
Address: Street	Apt	City	State	Zip Code	
Date of Birth	**Social Security #**	**Marital Status** S ☐ M ☐ W ☐ D ☐	**Sex:** M ☐ F ☐	**Age:**	
Home Phone:	**Cell Phone:**	**Email Address: ***			
Patient's Employer:	**Occupation:**	**Work Phone:**	**Ext:**		
Employer's Address: Street	City	State	Zip Code		
Spouse/Parent/Guardian (Circle One)	**Social Security #**	**Date of Birth:**	**Employer:**		
Spouse/Parent/Guardian **Employer's Address:**	City	State	Zip Code	**Work Phone:**	
Emergency Contact (outside the home)	**Relationship to Patient**	**Home Phone:**	**Work Phone:**		
Family Physician:	**Address:**	**Phone #:**			
Which pharmacy do you prefer to use?	**Pharmacy Address**				

May we speak with your ☐ Spouse ☐ Parent ☐ Emergency Contact ☐ Anyone ☐ Guardian ☐ Adult Children **about financial statements, test results or other services provided by our office regarding your medical treatment?**

Designated Representative: _____ ☐ YES ☐ NO

INSURANCE INFORMATION

PRIMARY INSURANCE Company Name	**Policy Holder:**	Policy Holder's Date of Birth:	Relation:
ID or Social Security #	**Group Number:**	Policy Holder's Employer:	
SECONDARY INSURANCE Company Name	**Policy Holder:**	Policy Holder's Date of Birth:	Relation:
ID or Social Security #	**Group Number:**	Policy Holder's Employer:	
VISION PLAN Plan Name	**ID Number:**	**Is prior Authorization required?** Yes ☐ No ☐	
What is the reason for your visit today?			
Race ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native ☐ Declined			
Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Declined			
Language ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other			

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments; however, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered, unless other arrangements have been made in advance.

AUTHORIZATION: I request that payment of authorized Medicare/Other Insurance company benefits be made either to me or on my behalf to Heart of America, P.A. for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid services or its intermediaries or carriers any information needed for this or related to a Medicare/Other Insurance company claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider or any other party who may be responsible for paying for my treatment.

* We may use your Email address to send you information about our practice and specials. However, we will not reveal your Email address to any other person or organization.

☐ I acknowledge receipt of notice of privacy practices
☐ I authorize Heart of America Eye Care to view my prescription from external sources.
☐ I acknowledge that I have read and understand the office polices.

Print Name: _____

Signature _____ **Date** _____

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PATIENT HISTORY RECORD

Patient's Name: _____ Birthdate: _____ Today's 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, arthritic, etc)*?
   - ❑ NO
   - ❑ YES – Please explain

   _____

2. Have you ever had any eye disease *(e.g. Glaucoma, cataract, "lazy" eye, retinal detachment)*?
   - ❑ NO
   - ❑ YES – Please explain

   _____

3. Do you take any eye medications or eye drops?
   - ❑ NO
   - ❑ YES – Please list

   _____

4. Do you take any other medications? If yes please list or attach list to form

   _____

5. Do you have any food or drug allergies? If yes please list:

   _____

6. Please list all MAJOR surgeries with the approximate year, and all MINOR surgeries you have had within the last 5 years.

   MAJOR SURGERIES

   _____

   _____

   MINOR SURGERIES

   _____

   _____

7. Do any medical conditions or eye disease run in your family *(e.g. glaucoma, macular degeneration, diabetes, etc)*?
   - ❑ NO
   - ❑ YES – Please explain

   _____

8. Do you smoke?
   - ❑ NO
   - ❑ YES – If Yes, how many packs/day? _____ for _____ yrs.

9. Do you drink alcohol?
   - ❑ NO
   - ❑ YES – If Yes, how much? _____

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Review of Systems: Please circle any medical condition below that you are being medicated or monitored for currently.

General Health	Endocrine	Gastrointestinal	Musculoskeletal
Hepatitis	Diabetes I _____ yrs.	Abdominal Pain	Muscle aches
HIV/AIDS	Diabetes II _____ yrs.	Diarrhea	Low back pain
Chronic Fever	Thyroid disorder	Ulcerative colitis	Myasthenia Gravis
Fatigue	Grave's Disease	Vomiting	Joint pain
Unexpected weight loss/gain		Crohn's disease	
High Cholesterol			

Heart	Respiratory	Immunologic	Skin Disorders
Irregular Heartbeat	Shortness of breath	Arthritis	Excessive dry skin
Congestive heart failure	Asthma	Rheumatoid arthritis	Eczema
Chest pain	Emphysema	Juvenile Rheumatoid Arthritis	Rosacea
High blood pressure	Wheezing	Ankylosing spondylitis	
Coronary artery disease	Coughing	Lupus	
Vascular problems		HLA-B27	

Ear, Nose, Throat	Urinary	Neurologic
Sinus problems	Excessive urination	Numbness
Sore throat	Pain with urination	Weakness
Hearing loss	Blood in urine	Headaches
Seasonal Allergies		Anxiety
		Depression
		Alzheimer's Disease

Other diseases not listed:

_____

_____

Physician Signature: _____ Date: _____