Drake Eye Center Forms

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of Drake Eye Center's Notice of Privacy Practices.
Patient Name

_____ _____
Signature of Patient Date

Who is allowed to pick up your eyewear, see your prescription information, and assist you in other ways concerning your vision care?

- ☐ Any family member or friend is allowed
- ☐ Only those listed below are allowed to assist me with my vision care *

_____

* Please notify staff concerning this request

Medical History Questionnaire

Name: _____ Date: _____

Birth Date: __ / __ / __ Last Medical Exam: __ / __ / __ Last Eye Exam: __ / __ / __

Name of Medical Doctor(s):

_____

Name of Pharmacy Used:

_____

PATIENT Past Medical History

Do you have any allergies to medications? □ yes □ no
If yes, explain: _____
List any medical conditions/ diagnoses you have:
_____
_____
_____
List any medications you take:
_____
_____
_____
List all major injuries, surgeries, and or hospitalizations you have had:
_____
_____

Do you wear glasses? □ yes □ no If yes, how old are they?
_____
Do you wear contacts? □ yes □ no If no, are you interested in trying them? □ yes □ no
If yes, what brand and wearing schedule?
_____

PATIENT Social History
What are your hobbies/ extracurricular activities?
_____
Do you use tobacco? □ yes □ no If yes, type/amount/how long:
_____
Do you drink alcohol? □ yes □ no If yes, type/amount/how long:
_____
Do you use recreational drugs? □ yes □ no If yes, type, amount/ how long:
_____

FAMILY History

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

Condition	*No*	*Yes*	*Unsure*	*Relationship to Patient*
Glaucoma	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Crossed Eyes	☐	☐	☐	_____
Retinal Detachment	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Lupus	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Other_____	☐	☐	☐	_____

Patient Information Sheet

PATIENT Review of Systems

Do you currently or have you ever had any problems in the following areas:

(If yes, please explain.)

System	*Yes*	*No*	*Explanation (if yes)*
Eyes	☐	☐	_____
Integumentary (Skin)	☐	☐	_____
Ears, Nose, Mouth, Throat	☐	☐	_____
Respiratory (Lungs, Breathing)	☐	☐	_____
Cardiovascular (Heart, Blood Pressure, etc.)	☐	☐	_____

Musculoskeletal (Muscles, Bones) ☐ ☐ _____

Gastrointestinal (Stomach, Intestines) ☐ ☐ _____

Genitourinary (Genitals, Kidney, Bladder) ☐ ☐

_____

Neurological (MS, Seizures, etc..) ☐ ☐ _____

Endocrine (Thyroid, Diabetes, etc..) ☐ ☐

_____

Psychiatric (Depression, Anxiety, etc..) ☐ ☐ _____

Hemotologic (Anemia, Bruising, etc.) _____

Allergic/Immunologic (allergies, lupus, etc.)

_____

Other (Cancer, STDs, etc..) ☐ ☐ _____

General Health/ Constitutional ☐ **Excellent** ☐ **Good** ☐ **Fair** ☐ **Poor**

_____ _____

Doctor's Signature **Review Date**

Patient Information / Authorizations

Personal Information

Last Name: _____ First Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Cell #: _____ (PLEASE DO NOT PUT HOME # OR LANDLINE #)

Email: _____ (WE NEED AN EMAIL FOR EVERY PATIENT)

SS #: _____ - _____ - _____ Birthdate: ____/____/_____

Marital Status: ☐ Married ☐ Single ☐ Widowed

Employment: □ Full-Time □ Part-Time Retired Student

How did you hear about us? Newspaper Billboard Telephone Book

Friend or relative (Name: _____)

Other _____

Insurance Information

Relationship to Insured: □ Self □ Spouse □ Child

Health Insurance: _____ Vision Insurance: _____

Insured's ID #: _____ Insured's ID #: _____

Group ID #: _____ Group ID #: _____

Insured's Information if *not* Self:
Last Name: _____ First Name: _____

Address: _____

Social ____ - ____ - _____ DOB: ___/___/_____ Employer: _____

Additional Health Plans:
Type of Insurance: _____

Insured's ID #: _____

Group ID #: _____

Authorizations

I hereby authorize the doctor to release any information required to process this claim. I also authorize my insurance benefits be paid directly to the doctor, and I understand I am financially responsible for all services not covered by my insurance.

** Payment for non-covered services (including co-payment) will be collected from the patient on the day of the exam.

Signed_____ **Date:** _____