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Date: _____

DEMOGRAPHICS

First Name _____ Middle name _____ Last name _____

Address _____ Suffix _____ Nickname _____

City _____ State _____ Zip Code _____

Date of Birth _____ SSN _____ Sex ○ Male ○ Female

Cell phone _____ Home phone _____ Work phone _____

Preferred contact method ☐ Cell ☐ Home ☐ Work

Email _____ Language _____

Race _____ Ethnicity _____

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INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Company Name _____

Policy Holder _____ Policy Holder Date of Birth _____

Relationship of Policy Holder ○ Spouse ○ Child ○ Other

Policy Number _____

SECONDARY INSURANCE:

Insurance Company Name _____

Policy Holder _____ Policy Holder Date of Birth _____

Relationship of Policy Holder ○ Spouse ○ Child ○ Other

Policy Number _____

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REASON FOR VISIT

Please tell us why you're coming to see us _____

EYE HISTORY

When was your last eye exam? _____

Have you ever had any eye injuries, surgeries for your eyes, or been diagnosed with an eye disease?

- ☐ Negative/No condition
- ☐ Glaucoma suspect
- ☐ Glaucoma
- ☐ Cataract
- ☐ Age related macular degeneration
- ☐ Surgery
- ☐ Patching
- ☐ Inflammatory disorders
- ☐ Strabismus
- ☐ Amblyopia
- ☐ Retinal degeneration
- ☐ Retinal hole
- ☐ Retinal detachment
- ☐ Keratoconus
- ☐ Injury
- ☐ Dry eye
- ☐ Nystagmus
- ☐ Retinal \ degeneration \ hole \ detachment
- ☐ Other

Do you wear glasses? ○ Yes ○ No

How old are your glasses? _____

What don't you like about your current glasses? _____

Do you wear contact lenses? ○ Yes ○ No

What brand of contact lenses do you wear? _____

What is your contact lens prescription for the right eye? _____

What is your contact lens prescription for the left eye? _____

What solution(s) do you use to clean your contact lenses? _____

Do you sleep in your contact lenses? ○ Yes ○ No

How often do you start a new pair of lenses? ○ Daily ○ Monthly ○ Quarterly ○ Other

What don't you like about your contact lenses? _____

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HISTORY OF PRESENT ILLNESS

Are you having any problems with your eyes? ○ Yes ○ No

What problem are you having? _____

Which eye is affected? _____

When did the problem begin? _____

Have you ever had this problem before?

○ New Condition ○ Return of Previous Condition ○ Ongoing Condition

What have you done to try to make the problem better?

☐ Taking medication ☐ Taking drops ☐ Treated by another provider

Are any symptoms associated with the problem?

☐ Burning
☐ Tearing
☐ Mattering
☐ Flashes
☐ Floaters
☐ Loss of sharpness
☐ Loss of vision
☐ Headache
☐ Photophobia
☐ Diplopia
☐ Red
☐ Itching

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REVIEW OF SYSTEMS

Allergy/Immunology
- ☐ Drug Allergies
- ☐ Environmental Allergies
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Sjogren's Syndrome
- ☐ Other
- ☐ Negative

Hematology/Lymphatic
- ☐ Anemia
- ☐ Large Volume Blood Loss
- ☐ Ulcer
- ☐ Hypercholesteremia
- ☐ Other
- ☐ Negative

Cardiovascular
- ☐ Hypertension
- ☐ Heart Disease
- ☐ Vascular Disease
- ☐ Congestive Heart Failure
- ☐ Stroke/CVA
- ☐ Other
- ☐ Negative

Psychological
- ☐ Depression
- ☐ Attention Deficit
- ☐ Anxiety Disorder
- ☐ Bipolar Disorder
- ☐ Other
- ☐ Negative

GastroIntestinal
- ☐ Crohns
- ☐ Colitis
- ☐ Ulcer
- ☐ Acid Reflux
- ☐ Celiac Disease
- ☐ Other
- ☐ Negative

Neurological
- ☐ Multiple Sclerosis
- ☐ Cerebral Palsy
- ☐ Tumors
- ☐ Stroke/CVA
- ☐ Migraines
- ☐ Autism Spectrum Disorder
- ☐ Epilepsy
- ☐ Other
- ☐ Negative

Ear, Nose & Throat
- ☐ Hearing Loss
- ☐ Sinusitis
- ☐ Dry Mouth
- ☐ Laryngitis
- ☐ Other
- ☐ Negative

Integumentary (SKIN)
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Herpest Simplex/ Cold Sores
- ☐ Herpes Zoster/ Shingles
- ☐ Other
- ☐ Negative

Genitourinary
- ☐ Kidney Disease
- ☐ Prostate Disease
- ☐ STD-herpetic/chlamydia
- ☐ Benign Prostate Hypertrophy
- ☐ Pregnant
- ☐ Nursing
- ☐ Herpes
- ☐ Chlamydia
- ☐ Other
- ☐ Negative

Musculoskeletal
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Ankylosing Spondylitis
- ☐ Osteoporosis
- ☐ Gout
- ☐ Osteoarthritis
- ☐ Other
- ☐ Negative

Constitution
(e.g. fever, weight loss, etc)
- ☐ Developmental Disabilities
- ☐ Cancer
- ☐ Fatigue Syndrome
- ☐ Other
- ☐ Negative

Respiratory
- ☐ Cigarette Smoker
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic Obstruction
- ☐ Sleep Apnea
- ☐ Other
- ☐ Negative

Endocrine
- ☐ Type 2 Diabetes Mellitus
- ☐ Type 1 Diabetes Mellitus
- ☐ Thyroid dysfunction
- ☐ Hormonal Dysfunction
- ☐ Other
- ☐ Negative

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MEDICATIONS

Do you take any prescription or non-prescription medications? ○ Yes ○ No

What is the name of the medication?	How often do you take this medication?

ALLERGIES

Are you allergic to any medications? ○ Yes ○ No

What medication(s) are you allergic to?	How severe is your allergy?	

Do you have any other allergies? ○ Yes ○ No

What medication(s) are you allergic to?	How severe is your allergy?	

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PAST, FAMILY AND SOCIAL HISTORY

Who is your primary care physician? _____

DIABETES HISTORY

Do you have diabetes? ○ Yes ○ No

What physician is treating your diabetes? _____

What was your last hemoglobin A1c reading? _____

FAMILY MEDICAL HISTORY

Does anyone in your family have any of the following medical conditions?

☐ None ☐ Hypertension ☐ Diabetes ☐ Cancer ☐ Thyroid ☐ Other

Does anyone in your family have any of the following eye conditions?

☐ None	☐ Severe Myopia	☐ Macular Degeneration	☐ Cataract	☐ Nystagmus
☐ Glaucoma suspect	☐ Severe Hyperopia	☐ Amblyopia	☐ Dry eye	
☐ Glaucoma	☐ Strabismus	☐ Retinal Detachment	☐ Other	

SOCIAL HISTORY

Do you drink alcohol? ○ Yes ○ No ○ Unknown

How often do you drink alcohol? _____

Do you use tobacco products? ○ Yes ○ No ○ Unknown

Palatine Vision Center

Insurance Policies and Billing Procedures/Privacy Practices Acknowledgement

I authorize Palatine Vision Center, LLC to use this authorization in place of my physical signature on submissions to my insurance carrier.

I authorize assignment of payments directly to Palatine Vision Center, LLC when applicable.

I understand that it is my responsibility to know the details of my individual insurance plan deductibles and co-pay/co-insurance amounts.

I understand that although a procedure may be covered by my insurance, I may have out-of-pocket amounts for co-pays and coinsurance or if I have not yet met my deductible that will be payable to Palatine Vision Center.

I understand that I am ultimately responsible for my (or my child's) charges if unpaid or denied by insurance as my insurance is a contract between myself and my insurance company and payment for materials and services rendered is due regardless of insurance determination of coverage.

In the event that an outstanding balance is transferred to collections, after 120 days past due, a collections fee equal to 25% of unpaid balance will be added to the amount due.

I understand that the billing of insurance is determined by the reason for my visit as well as ultimate diagnosis. I understand that vision plans (ie. VSP, EyeMed, etc.) covers only routine/preventative eye examinations for purposes of vision correction and/or eye health screening.

I understand that examinations for medical conditions such as diabetes, cataracts, glaucoma, eye pain, redness, floaters, dry eye, blurred vision not due to the need for glasses/contacts, among other problem focused complaints are not addressed during a routine/preventative examination and any visit for those complaints will be considered a medical visit and will be billed through my medical insurance provider.

I understand that, outside of urgent eye issues, I can request that my vision plan be used if eligible and may then return at a later date and time to address specific medical concerns.

I have been given or offered a copy of this practice's notices of HIPAA privacy practices.

Print:_____

Signed: _____ *Date:* _____