DR. ANDREW WARD, DR. PATRICIA WARD ADAMS, DR. MURRAY ADAMS

WELCOME TO OUR OFFICE

NAME:_____ BIRTHDAY:_____/_____/_____ AGE: _____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

PLEASE CIRCLE THE BEST CONTACT NUMBER

HOME PHONE:_____ CELL PHONE:_____ Can we text this number Y ☐ N ☐

Sex: ☐ M ☐ F SS#:_____-_____-_____ Marital Status:_____

EMPLOYER/OCCUPATION:_____ WORK PHONE:_____

FAMILY DOCTOR: _____ DATE OF LAST PHYSICAL:_____

EMAIL:_____ Reason For Visit: _____

How did you find out about our office?_____

RESPONSIBLE PARTY'S INFORMATION (if minor)

Name:_____ Relationship to patient:_____

Street Address:_____ City:_____ State:_____ Zip:_____

Employer:_____ Work Phone:_____

Date of Birth:_____ Social Security No:_____

Please circle: Visual Insurance Medicaid Medicare Supplement Lions Club other_____

INSURANCE INFORMATION

Name of Insurance:_____ Name of Cardholder: _____

ID#:_____ Cardholder's Social Security No:_____ Cardholder's Birthday:_____/_____/_____

Relationship to patient:_____Cardholder's Employer:_____

WE WILL BE HAPPY TO PROCESS YOUR INSURANCE CLAIM BUT YOU MUST HAVE VALID CARD OR INFORMATION ON YOUR PLAN. IT IS YOUR RESPONSIBILITY TO MAKE SURE YOUR INSURANCE PAYS IN A TIMELY MANNER. THERE WILL BE A 2% OR $2.OO MINIMUM MONTHLY SERVICE CHARGE ON ALL ACCOUNTS OVER 45 DAYS OLD. THERE WILL BE A $10.00 MONTHLY SERVICE FEE FOR ACCOUNTS THAT NO PAYMENT HAS BEEN MADE.

SIGNATURE:_____DATE:_____

Medicare and Insurance Signature: I request that payment of authorized Medicare, Medicaid, or any other vision/medical insurance benefits, either to me or on my behalf, be made to Advantage Eye Care for any services rendered. I authorize Advantage Eye Care to release to the Health Care Financing Administration and its agent or any other insurance carrier, any information needed to determine these benefits or the benefits payable for related services. I also understand that if my insurance company does not provide payment to Advantage Eye Care, I will be billed for said service. This will stay in effect unless written documentation is given requesting that this agreement cease.

Signature:_____ **Date**:_____

PLEASE NOTIFY RECEPTIONIST IF YOU ARE WEARING CONTACTS

Please turn form over and complete side two

Medical History

Do you have any allergies to medications? ☐ no ☐ yes If yes, please list: _____

List any **PRESCRIPTION MEDICATIONS** and any **OVER THE COUNTER MEDICATIONS** you take:

_____

_____

List all major injuries, surgeries: _____

Are you pregnant and /or nursing? ☐ no ☐ yes If yes, pregnancy due date:_____

Do you wear glasses? ☐ no ☐ yes Do you wear contact lenses? ☐ no ☐ yes

Family History

Please note any **family** history for the following conditions. If yes, please check box and the family relationship (M = mother, F= father, S = siblings, Maternal/Paternal GM/GF=Grandmother and Grandfather) to you.

☐ Diabetes _____ ☐ Glaucoma_____

☐ Macular Degeneration _____ ☐ Retinal Detachment_____

☐ High blood pressure_____ ☐ Cataracts_____

☐ None of the above

Social History *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

☐ Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you use tobacco products? ☐ no ☐ yes If yes, type/how long: _____

Do you drink alcohol? ☐ no ☐ yes If yes, social use only ☐ daily ☐ above average use ☐

Do you use any illegal/narcotic drugs? ☐ no ☐ yes If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis ☐ None of these

Review of Systems

Do you presently have any problems in the following areas? If YES, please give an explanation:

	YES	NO	EXPLANATION OF PROBLEM
EYES			
Redness	☐	☐	
Itching	☐	☐	
Mucous discharge	☐	☐	
Sties, chalazion	☐	☐	
Infection of eye/lid	☐	☐	
Eye pain or soreness	☐	☐	
Sandy/Gritty feeling	☐	☐	
Burning	☐	☐	
Excess tearing	☐	☐	
Dryness	☐	☐	
Glare/light sensitive	☐	☐	
Double vision	☐	☐	
Loss of side vision	☐	☐	
Blurred/distorted vision	☐	☐	
Floaters	☐	☐	
Flashes of light	☐	☐	
Are you having any difficulty?			
Reading small print	☐	☐	
Reading traffic signs	☐	☐	
Watching TV/Movies	☐	☐	
Trouble at computer	☐	☐	

Do you presently have any problems in the following area?

	YES	NO
CONSTITUTIONAL		
Fever	☐	☐
Weight Loss/Gain	☐	☐
INTEGUMENTARY (Skin)		
Skin disease	☐	☐
Skin cancer	☐	☐
Breast cancer	☐	☐
NEUROLOGICAL		
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
Stroke	☐	☐
GENITOURINARY		
Prostate cancer	☐	☐
Kidney disease	☐	☐
ALLERGIC/IMMUNOLOGIC		
General allergies	☐	☐
Seasonal allergies	☐	☐
Autoimmune	☐	☐

	YES	NO
EARS, NOSE, MOUTH, THROAT		
Hearing loss	☐	☐
Sinus Congestion	☐	☐
Chronic cough	☐	☐
Dry throat/mouth	☐	☐
CARDIOVASCULAR		
Heart attacks	☐	☐
High Blood Pressure	☐	☐
Vascular Disease	☐	☐
Chest pain	☐	☐
Congestive heart failure	☐	☐
Irregular/fast heartbeat	☐	☐
Heart murmur	☐	☐
RESPIRATORY (Lungs/Breathing)		
Lung Cancer	☐	☐
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐

	YES	NO
ENDOCRINE		
Diabetes	☐	☐
Thyroid problems	☐	☐
PSYCHIATRIC		
Depression	☐	☐
Anxiety	☐	☐
BONES/JOINTS/MUSCLES		
Rheumatoid Arthritis	☐	☐
Muscle/Joint Pain	☐	☐
LYMPHATIC/ HEMATOLOGIC		
Lymph nodes	☐	☐
Anemia	☐	☐
Sickle Cell disease	☐	☐
Bleeding disorder	☐	☐
Leukemia	☐	☐
GASTROINTESTINAL		
Jaundice/Hepatitis	☐	☐
Ulcers/Bleeding	☐	☐

_____ _____

Doctor's Signature Date