EYE MEDICAL GROUP - Norman Eye Clinic

Last name ________________________ First Name ________________ MI ____ DOB ___ / ___ /______

Established Patient Form*: Mark **"NO CHANGES"** or provide new information for every section if applicable. Sign at the bottom*

Patient Information ◻ **NO CHANGES From Previous Exam (Skip this section)**

Address ________________________ City __________ State ___ Zip______

Cell Phone (____)______________ Home Phone (____)______________ Work Phone (____)______________

Email ________________________ Parent/Guardian *(If Applicable)* ________________________

Today's Exam: *(circle all that apply)* Medical Glasses/Contacts Reason for Visit______________ Referred by________

Insurance Information ◻ **Skip this section if we have a copy of your current insurance cards**

1)Primary Medical ________________________ ID ______________ Group __________

2)Secondary Medical ________________________ ID ______________ Group__________

3)Primary Vision________________________ ID ______________ Group__________

4)Other____

Insured Name (if different from patient)________________ DOB _____ / _____ / ______ SSN ____ - ___ - ______

Relationship to patient________________________ Employer ________________________

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Medical History ◻ **NO CHANGES From Previous Exam (Skip this section and sign at the bottom)**

(Circle "Yes" if applicable) Primary Care Physician ________________

Eye surgeries? Yes Type ________________________ Dates______________

Eye injuries? Yes Type ________________________ Dates ______________

Do you wear glasses? Yes Frequency ________________ Age of Glasses ________________

And contact lenses? Yes Type ________ Solution__________ Replaced every __________ Sleep? Yes ________

Personal or family history of: (If Family specify)

Glaucoma Yes Self / Family ______________ Macular Degeneration Yes Self / Family ______________

Cataract Yes Self / Family ______________ Retinal Detachment Yes Self / Family ______________

Dry Eyes Yes Foreign Body Yes Itchy Eyes Yes Watery Eyes Yes Painful Eyes Yes

Red Eyes Yes Floaters Yes Eye Strain Yes Light Sensitivity Yes Difficult night driving Yes

Flashes of Light Yes Eye Infection Yes Additional Eye Health Information:________________________

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Personal history of the following medical conditions:

Diabetes Yes Type 1 or Type 2 A1C value __ High Blood Pressure Yes High Cholesterol Yes

Allergies Yes Cardiovascular Disease Yes Respiratory (e.g. Asthma) Yes Endocrine Disorder (e.g. Thyroid) Yes

Headaches Yes Autoimmune Disease Yes ENT (e.g. Sleep apnea) Yes Infectious Disease (e.g. HIV) Yes

Blood Disease Yes Neurological Disorder Yes Mental Disorder Yes Urinary Disorder (e.g. Prostate) Yes

Muscle Disorder Yes Bone Disease Yes Cancer (Specify) Yes ________________

Other or additional information (e.g. currently pregnant)________________________

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If family history of any of the above medical conditions, specify:________________________

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Allergic to any medications? (circle) None or Yes, specify: ________________________

Smoke Yes Frequency ____________ Alcohol Yes Chemical Dependency:________ Yes

Please list any surgeries and approximate dates:________________________

▪ *I have been informed and offered a copy of Eye Medical Group's Notice of Privacy Practices. (Please review the laminated privacy notice)*

▪ *I realize that Eye Medical Group is filing my insurance as a courtesy. In the event that my insurance does not pay as expected, I will be responsible for any balance due. I fully understand that insurance co-pays and all non-covered fees are due at the time of service. I hereby authorize Eye Medical Group to release all information necessary to secure the payment of benefits. I request that payment of authorized insurance benefits be made either to me or on my behalf to my physician for any services furnished to me by that physician. I authorize the use of this signature on all insurance submissions.*

________________________________ ________________

Responsible Party Signature / Date Eye Medical Group Physician