Eye Services of Jackson

Date_______________

Patients Name ____ ☐ Mr ☐ Mrs ☐ Dr ☐ Miss ☐ Ms ☐ Rev

How did you hear about Eye Services?______________________________

Date of Last Vision Exam______________ With Whom______________________

Briefly explain the reason for your visit ______________________________

____

Do You Wear Eye Glasses? ☐ Yes ☐ No

Are You Interested in Glasses? ☐ Yes ☐ No Type of Lenses ____________________

Do You Wear Contact Lenses? ☐ Yes ☐ No Type of Lenses ____________________

Are You Interested in Contact Lenses? ☐ Yes ☐ No Type of Lenses ____________________

Are you interested in surgery to reduce or eliminate your dependency on glasses and/or contact lenses? ☐ Yes ☐ No

Please answer the Health Questions below by checking either Yes or No

Diabetes	☐ Yes ☐ No	Heart Abnormalities	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Cholesterol	☐ Yes ☐ No
Thyroid Problems	☐ Yes ☐ No	Skin Disorders	☐ Yes ☐ No
Neurological Problems	☐ Yes ☐ No	HIV/AIDS	☐ Yes ☐ No
Kidney Problems	☐ Yes ☐ No	TB/Pneumonia	☐ Yes ☐ No
Lung/Asthma Problems	☐ Yes ☐ No	Hepatitis TB/Pneumonia	☐ Yes ☐ No
Pregnant (Currently)	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Hay Fever	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No
Bleeding Tendencies	☐ Yes ☐ No	Prostate Problems	☐ Yes ☐ No
Sinus Problems	☐ Yes ☐ No	Tobacco Use	☐ Yes ☐ No
Headaches	☐ Yes ☐ No	Alcohol Use	☐ Yes ☐ No
Stomach Problems	☐ Yes ☐ No		

List any current medications ______________________________________

____

Eye Drops ____

____

List any allergies to medications ____________________________________

____

Primary Care Physician____

Family History

Macular Degeneration	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	Strabismus (lazy eye)	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Retinal Problems	☐ Yes ☐ No
Blindness	☐ Yes ☐ No		

Have you had any eye injuries or eye surgeries? If yes please explain ____________________

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Have you had any general surgeries? If yes please explain ___________________________

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Have you ever been diagnosed with any of the following

Macular Degeneration	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No
Retinal Problems	☐ Yes ☐ No	Strabismus (lazy eye)	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	Serious Eye Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No		

Insurance Information

Patients Name ______________________ Sex ________
Address ______________________ City ________ State ______ Zip ________
Home Phone ______________________ Work Phone ______________________
Cell Phone ______________________ Email ______________________
Texting ☐ Yes ☐ No

Patient Date of Birth ______________________ Age ______________________
Social Security Number ______________________
Occupation ______________________
Name of Employer ______________________
Special Visual Demands (Work or Hobbies) ______________________

Do You Have Vision Insurance ☐ Yes ☐ No
Do You Have Medical Insurance ☐ Yes ☐ No

Primary

Primary Vision Insurance ______________________
Medical Insurance ______________________
Name of Policy Holder ______________________ Policy Holder D.O.B. ____________
Relationship to Policy Holder ______________________
Policy Holder Social Security ______________________ Work Phone ______________________
Employer of Policy Holder ______________________

Secondary

Second Vision Insurance ______________________
Second Medical Insurance ______________________
Name of Policy Holder ______________________ Policy Holder D.O.B. ____________
Relationship to Policy Holder ______________________
Policy Holder Social Security ______________________ Work Phone ______________________
Employer of Policy Holder ______________________

In Case of Emergency

Emergency Contact ______________________ Phone Number ____________

I acknowledge that I have received a copy of Eye Services Notice of Privacy Practices.

Please Sign

I authorize the release of any medical information necessary to process insurance claims and request payment to either myself or the party who accepts assignment. I state that the information on this document is correct to the best of my knowledge. I permit a copy of these benefits to myself or the party who accepts assignment.

Signed ______________________ Date ______________________