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 _____

_____

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

_____

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 _____

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 _____