Eye and Hearing Center
Welcome Back To Our Office

Welcome to Eye and Hearing Center. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

☐Mr. ☐Miss ☐Mrs. ☐Ms. ☐Male ☐Female

First Name ____ Last Name ____ MI ____ Preferred Name ____

Street Address ____ City ____ State ____ Zip ____

Social Security Number ____ Date of Birth ____ Home Phone - Include Area Code ____ Day Phone ____

Email Address ____ Guardian ____ Person Responsible for Account ____

Emergency Contact ____ Emergency Phone ____

How were you referred to our office?
☐Phone Book ☐School ☐Advertisement ☐Patient
☐Insurance Listing ☐Drive by ☐Other ☐Doctor

Who were you referred by? ____

PRIMARY INSURANCE INFORMATION

Name and Address of Primary Insurance Company ____ City ____ State ____ Zip ____

☐M ☐F Insured's First Name ____ MI ____ Insured's Last Name ____

Insured's Identification Number ____ Group Number ____ Insured's Date of Birth ____

Patient Relationship to Insured
☐Self ☐Spouse ☐Child ☐Other

Patient Status ☐Single ☐Married ☐Other
☐Full Time Student ☐Part Time Student ☐Employed

SECONDARY INSURANCE INFORMATION

Name and Address of Secondary Insurance Company ____ City ____ St ____ Zip ____

☐M ☐F Insured's First Name ____ MI ____ Insured's Last Name ____

Insured's Id Number ____ Group Number ____ Insured's DOB ____

Patient Relationship to Insured
☐Self ☐Spouse ☐Child ☐Other

Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to Union & Labor Eye & Hearing Center. I understand that Blue Cross - Blue Shield of GA will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Signature ____ Date ____

Eye and Hearing Center
PATIENT HISTORY AND INFORMATION

PRIMARY CARE PHYSICIAN

____
Primary Care Physician and Clinic Name

______________________________________ __________________ ___ ________ ___________
Address of Primary Care Physician City St Zip Phone

REFERRING PHYSICIAN

____
Referring Physician and Clinic Name

______________________________________ __________________ ___ ________ ___________
Address of Referring Physician City St Zip Phone

HEALTH HISTORY

What is the main reason for today's exam? _______________ When was your last exam? _________
When was your last health exam? _____________

Past Illnesses or Injuries: ____

Past Surgeries: ____

Current Medications: ____

____

Current Eye Drops: ____

____

Medicines that cause reactions or sensitivities: ____

Specific Allergies: ____

EYE HISTORY

Glaucoma	☐Yes ☐No	Dryness	☐Yes ☐No	Strabismus-Crossed Eyes	☐Yes ☐No
Cataract	☐Yes ☐No	Excess Tearing/Waterin	☐Yes ☐No	Blurred Vision Distance	☐Yes ☐No
Macular Degeneration	☐Yes ☐No	Eye Pain or Soreness	☐Yes ☐No	Blurred Vision Near	☐Yes ☐No
Retinal Detachment	☐Yes ☐No	Foreign Body Sensation	☐Yes ☐No	Distorted Vision-Halos	☐Yes ☐No
Color Blindness	☐Yes ☐No	Infection of Eye/Lid	☐Yes ☐No	Double Vision	☐Yes ☐No
Headaches	☐Yes ☐No	Itching	☐Yes ☐No	Floaters or Spots	☐Yes ☐No
Glare/Light Sensitivity	☐Yes ☐No	Mucous Discharge	☐Yes ☐No	Fluctuating Vision	☐Yes ☐No
Tired Eyes	☐Yes ☐No	Drooping Eyelid	☐Yes ☐No	Loss of Vision	☐Yes ☐No
Amblyopia-Lazy Eye	☐Yes ☐No	Redness	☐Yes ☐No	Loss of Side Vision	☐Yes ☐No
Burning	☐Yes ☐No	Sandy/Gritting Feeling	☐Yes ☐No		

GENERAL HEALTH CONDITION

Fever	☐Yes ☐No	Respiratory-Asthma	☐Yes ☐No	Anxiety or Depression	☐Yes ☐No
Weight Loss	☐Yes ☐No	Gastrointestinal	☐Yes ☐No	Thyroid, Diabetes	☐Yes ☐No
Other Symptoms	☐Yes ☐No	Kidney	☐Yes ☐No	Blood/Lymph	☐Yes ☐No
Ears, Nose, Throat	☐Yes ☐No	Muscle, Bones, Joints	☐Yes ☐No	Allergic	☐Yes ☐No
Cardiovascular- High	☐Yes ☐No	Skin	☐Yes ☐No	Pregnant	☐Yes ☐No
Blood Pressure	Neurological-Multiple Sclerosis		☐Yes ☐No	Nursing	☐Yes ☐No

FAMILY HISTORY

Amblyopia-Lazy Eye	☐Yes ☐No	Retinal Detachment	☐Yes ☐No	High Blood Pressure	☐Yes ☐No
Blindness	☐Yes ☐No	Strabismus-Eye Turn	☐Yes ☐No	Kidney Disease	☐Yes ☐No
Cataract(s)	☐Yes ☐No	Arthritis	☐Yes ☐No	Lupus	☐Yes ☐No
Color Blindness	☐Yes ☐No	Cancer	☐Yes ☐No	Stroke	☐Yes ☐No
Glaucoma	☐Yes ☐No	Diabetes	☐Yes ☐No	Thyroid Disease	☐Yes ☐No
Macular Degeneration	☐Yes ☐No	Heart Disease	☐Yes ☐No	Others	☐Yes ☐No

Eye and Hearing Center
MEDICAL HISTORY QUESTIONAIRE

SOCIAL HISTORY

Current Occupation:____________________________ Years _______ Employer_____________________

SPECTACLE LENS HISTORY

Do you use a computer? ☐Yes ☐No How many hours/day?____ Distance from Computer?______

Do you drive? ☐Yes ☐No Mileage to work each way? ______

Do you have glare problems? ☐Yes ☐No

Do you have visual difficulty when driving? ☐Yes ☐No

Do you have problems with night vision? ☐Yes ☐No Since: ________

Do you currently wear glasses ? ☐Yes ☐No

Type of glasses: ☐FullTime ☐PartTime ☐Distance ☐Close

Glasses Owned: ☐SingleVision ☐Bifocals ☐Trifocals ☐Backup ☐Safety ☐Sports ☐Progressive

Have you had trouble in the past with glasses? ☐Yes ☐No

Do you wear sunglasses? ☐Yes ☐No Are your sun glasses your current prescription? ☐Yes ☐No

SPECIAL EYEWEAR NEEDS

☐Computer (special prescriptions, special anti-glare tints or coatings)
☐Safety Glasses (gardening, woodworking, welding)
☐Occupational (mechanics, plumbers, pilots)
☐Sports/Hobbies (racquet sports,motorcycle)

CONTACT LENS HISTORY

If not a contact lens wearer, are you interested in trying contact lenses at this time? ☐Yes ☐No

Have you ever tried to wear contact lenses? ☐Yes ☐No Reason for stopping?

Do you currently wear contact lenses? ☐Yes ☐No Since

Type and brand of contact lenses: _________________ Today's wearing time? ____________

How many hours/day?___________________ How many days/week? ___________

Please rate the following on a scale of 1-10, with 1 being POOR to 10 being EXCELLENT

	Right	Left		Right	Left		Right	Left
Lens Comfort	_____	_____	Distance Vision	_____	______	Near Vision	_____	_____

What Solutions do you use? Cleaner_______________ Disinfectant___________ Enzyme______________

SOCIAL HISTORY

Do you use nutritional supplements (vitamins etc.)? ☐Yes ☐No

Do you engage in regular exercise? ☐Yes ☐No

Do you drink alcohol? ☐Yes ☐No If Yes, how much/often: ☐Occasional ☐1 Per Day ☐2-3/day ☐4+/day

Do you smoke? ☐Yes ☐No If Yes, how much/often: ☐Occasional ☐1/2 pack/day ☐1 pack/day

Method of Tobacco Intake: ☐Smoking ☐Chewing

Do you use Illegal Drugs: ☐Yes ☐No

Hobbies/ Interests: ____