Welcome!

We are pleased to welcome you to **Advanced Eyecare**. We look forward to meeting your eye care needs with professional care. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Patient Name_____ Address_____

City_____ State_____ Zip_____ Phone No._____

E-mail Address_____ Daytime Phone No_____ Cell Phone No_____

Male_____ Female_____ Please Circle One: Single Married Divorced Widowed Date of Birth_____ Age____

Soc Sec #_____ Driver's License #_____ State_____

Employed by_____ Employer's Address_____

Employer's Phone_____ Occupation_____

Major Medical Ins Co Name_____ Ins ID#/Policy#/Group#_____

Vision Ins Co Name_____ Ins ID#/Policy#/Group#_____

Spouse's Name_____ Date of Birth_____

Soc Sec #_____ Driver's License #_____ State_____

Employed by_____ Employer's Address_____

Employer's Phone_____ Occupation_____

Major Medical Ins Co Name_____ Ins ID#/Policy#/Group#_____

Vision Ins Co Name_____ Ins ID#/Policy#/Group#_____

If Minor: If you are a student, name of school/college:_____ Grade_____

Father's Name_____	Mother's Name_____
Date of Birth_____	Date of Birth_____
Social Security No_____	Social Security No_____
Driver's License No_____ State_____	Driver's License No_____ State_____
Employer_____	Employer_____
Employer Address_____	Employer Address_____
Vision Ins Co Name_____	Vision Insurance Co Name_____
ID#/Policy #/Group#_____	ID#/Policy #/Group#_____
Major Medical Ins Co Name_____	Major Medical Ins Co Name_____
ID#/Policy #/Group#_____	ID#/Policy #/Group#_____

By signing below, you signify that you agree that in the course of providing service to you, we create, receive, send and store health information that identifies you. It is often necessary to use and disclose your health information in order to treat you, to obtain payment for our services, refer you to a another specialist, and conduct health care operations involving our office.

I certify that the above information is true and correct. I authorize Dr. Soares to act as my agent in helping me obtain payment of my insurance benefits, and I authorize payment of these benefits directly to Trajan J. Soares, O.D., on my behalf for any services and materials furnished. If I have other health insurance coverage, my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above. I understand that any quote from the insurance company is only an estimate and not an actual guarantee of payment. I understand I am responsible for the balance of fees due.

_____ _____

Patient/Parent Signature Today's Date

Person to contact in case of an emergency: _____Phone Number:_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following. Also place a mark to indicate if a blood relative (for example: your mom, dad, brother, sister, grandparents, aunts, uncles) has had any of the following problems:

	Yourself	Family Member	Who:		Yourself	Family Member	Who:
AIDS/HIV	□ Yes □ No	□Yes □No	_____	Hepatitis (Type___)	□ Yes □ No	□ Yes □ No	_____
Arthritis	□ Yes □ No	□Yes □No	_____	High Blood Pressure	□ Yes □ No	□ Yes □ No	_____
Artificial Heart Valve	□ Yes □ No	□Yes □No	_____	Kidney Disease	□ Yes □ No	□ Yes □ No	_____
Artificial Joints	□ Yes □ No	□Yes □No	_____	Lazy Eye	□ Yes □ No	□ Yes □ No	_____
Asthma	□ Yes □ No	□Yes □No	_____	Lupus	□ Yes □ No	□ Yes □ No	_____
Bleeding	□ Yes □ No	□Yes □No	_____	Migraine Headaches	□ Yes □ No	□ Yes □ No	_____
Blindness	□ Yes □ No	□Yes □No	_____	Pacemaker	□ Yes □ No	□ Yes □ No	_____
Cancer	□ Yes □ No	□Yes □No	_____	Psychiatric	□ Yes □ No	□ Yes □ No	_____
Cataracts	□ Yes □ No	□Yes □No	_____	Poor Color Vision	□ Yes □ No	□ Yes □ No	_____
Chemical Dependency	□ Yes □ No	□Yes □No	_____	Retinal Disease	□ Yes □ No	□ Yes □ No	_____
Diabetes	□ Yes □ No	□Yes □No	_____	Rheumatic Fever	□ Yes □ No	□ Yes □ No	_____
Drug Sensitivity	□ Yes □ No	□Yes □No	_____	Shingles	□ Yes □ No	□ Yes □ No	_____
Emphysema	□ Yes □ No	□Yes □No	_____	Skin Conditions	□ Yes □ No	□ Yes □ No	_____
Epilepsy	□ Yes □ No	□Yes □No	_____	Stroke	□ Yes □ No	□ Yes □ No	_____
Eye Surgery	□ Yes □ No	□Yes □No	_____	Thyroid Conditions	□ Yes □ No	□ Yes □ No	_____
Flashes	□ Yes □ No	□Yes □No	_____	Tuberculosis	□ Yes □ No	□ Yes □ No	_____
Floaters or Spots	□ Yes □ No	□Yes □No	_____	Turned Eye	□ Yes □ No	□ Yes □ No	_____
Glaucoma	□ Yes □ No	□Yes □No	_____	Ulcers	□ Yes □ No	□ Yes □ No	_____
Hay Fever	□ Yes □ No	□Yes □No	_____	Vascular Disease	□ Yes □ No	□ Yes □ No	_____
Heart Condition	□ Yes □ No	□Yes □No	_____	Vision - Sudden Loss	□ Yes □ No	□ Yes □ No	_____
Itching Eyes	□ Yes □ No	□Yes □No	_____	Weight Loss/Gain	□ Yes □ No	□ Yes □ No	_____
High Cholesterol	□ Yes □ No	□Yes □No	_____	Alcohol Use	□ Yes □ No		
Women: Are you pregnant and/or nursing?		□Yes □No		Tobacco Use	□ Yes □ No		

MEDICATIONS

List any medications you are currently taking, including eye drops:

_____

_____

Pharmacy Name:_____

Phone (_____)_____

ALLERGIES

List your allergies to medications or other substances:

_____

_____

_____

_____

Physician's Name:_____

Date of Last Visit:_____

Date of Last Eye Exam:_____

Name of Last Eye Doctor:_____

Do you wear glasses: □ Yes □ No

□ All The Time □ Occassionally □ Reading □ Driving □ TV

Do you wear contacts: □ Yes □ No

Type/Brand:_____ Hours/Day:_____

Describe any problems you have with your contacts/glasses:_____

_____		_____	
Patient/Parent Signature	Date	_Doctor Signature	Date
_____		_____	
Patient/Parent Signature	Date	_Doctor Signature	Date
_____		_____	
Patient/Parent Signature	Date	_Doctor Signature	Date