Special-Eyes Vision Center

Please print

PATIENT INFORMATION DATE:_____

NAME (Last, First, Mi)_____

DATE OF BIRTH_____ AGE_____ SS#_____

ADDRESS_____

CITY_____ STATE _____ ZIP CODE_____

HOME PHONE_____ CELL_____ WORK_____

May we notify you by text? Y/N

EMAIL_____ OCCUPATION_____

EMPLOYER_____ REFERRED BY_____

INSURANCE INFORMATION (Tricare patients **MUST** disclose any other health insurance)

VISION INSURANCE

Insurance Co:_____

ID#:_____

MEDICAL INSURANCE

Insurance Co:_____

ID#:_____

Relationship to insured: Self_____ Spouse_____ Child_____

If insured by Tricare, is the sponsor active duty?_____ or retired?_____

FINANCIAL RESPONSIBILITY

I permit a copy of this authorization to be used in place of the original, and request payment of insurance benefits to Dr. Jennifer Goette. I understand and accept financial responsibility for all and any services rendered to me. I give permission for my health related information to be released to a third party for insurance eligibility and payment considerations.

Signature:_____ Date:_____

NOTICE OF PRIVACY PRACTICES

A "Notice of Privacy Practices" that describes how my protected health information is used/disclosed has been made available to me. I understand that I may request a printed copy at any time.

Signature:_____ Date:_____

EMERGENCY INFORMATION

In case of emergency, please notify:_____ Phone#_____

Medical History and Review of Systems

Review of Systems
Do YOU have any problems in the following areas? (Please check if applicable).

Eyes
Glaucoma _____
Macular Degeneration _____
Retinal Detachment _____
Cataracts _____
Eye pain or soreness _____
Double vision _____
Dryness _____
Mucous discharge _____
Redness _____
Flashes/Floaters _____
Burning/Itching _____
Blurred vision _____
Crossed/Lazy eyes _____
Light sensitivity _____

Constitutional
Fever _____
Weight Changes _____

Integumentary(skin)
Rosacea _____
Skin cancer _____

Neurological
Headaches/Migraines _____
Multiple Sclerosis _____
Bell's Palsy _____

Allergic/Immunicological
Lupus _____
AIDS/HIV _____
Sjorgren's Syndrome _____

Respiratory
Asthma _____
Emphysema _____

Vascular/Cardiovascular
Heart Disease _____
High Blood Pressure _____
High Cholesterol _____

Gastrointestinal
Acid Reflux _____
Hepatitis _____

Bones/Joints/Muscles
Osteoarthritis _____
Rheumatoid Arthritis _____

Lymphatic/Hematological
Bleeding Disorders _____
Anemia _____
Sickle Cell Trait _____

Endocrine
Thyroid _____
Diabetes _____
Pituitary Tumor _____

Ears, Nose, Throat
Hay Fever _____
Sinusitis _____
Hearing Loss _____

Psychiatric
Depression _____
ADD/ADHD _____
Autism _____

Please list all medications:_____

_____

Allergies to medications:_____

FAMILY HISTORY

Do any members of your **immediate family** (parents, grandparents, siblings, children) suffer from any of the following conditions?

Blindness	_____	Diabetes	_____
Lazy Eye	_____	Hypertension	_____
Cataracts	_____	Heart Disease	_____
Glaucoma	_____	Thyroid	_____
Macular Degeneration	_____	Cancer	_____
Retinal Detachment	_____	Lupus	_____

Other disorders not listed above:_____

SOCIAL HISTORY

Smoking: Are you a current smoker? Yes/No Are you a former smoker? Yes/No

Alcohol: Do you drink alcohol? Never / Seldom / Socially / Above average / Daily

Primary Care Physician:_____

Please list any eye related disease, disorders or injuries:_____

_____

Have you had eye surgery? Lasik / Cataract Removal / PRK / Corneal Transplant?

Do you have glasses today? Yes/No Is this a contact lens exam? Yes/No

Have you worn contacts? Yes/No Do you sleep in your contacts? Yes/No

Ladies, are you pregnant? Yes/No Nursing a baby? Yes/No

Reason for today's visit:_____

Patient signature:_____Date_____