SOUTHERLIN
FAMILY EYE CARE

Patient Information Form Today's Date_____

Name_____Phone_____

Address_____ Cell Phone_____

Birth Date __/___/____ Soc. Sec. No. ____-___-____ Guardian (if applicable) _____

Medical Insurance _____ Vision Insurance _____

Current Medications (including vitamins or OTC products)

_____

_____

Women: Are you pregnant or nursing? ____yes ____no

Allergies to Medications _____

Please place a "x" in the box if ***you*** have been diagnosed with: ____glaucoma _____cataracts

____macular degeneration ___diabetes ____high blood pressure _____cancer

Please "x" and **tell who in *your family*** have been diagnosed with: _____glaucoma

____macular degeneration _____cataract _____other eye disease

_____high blood pressure _____diabetes

Your Occupation_____ Place of Employment _____

Your computer Use per day ____hrs Your hobbies _____

Please "x" any disease that ***you*** have:

- **Allergic/Immunologic:** ___drug allergy to what? _____

  ___environmental allergy to what? _____

  ___rheumatoid arthritis ___ lupus ___sarcoid

- **Eyes:** ___glaucoma ___cataracts ___macular degeneration ___eye surgery

  ___redness ___blurred vision ___double vision ___burning/dryness ___floaters

- **Musculoskeletal:** ___fibromyalgia ___arthritis ___joint pain

- **Cardiovascular:** ___heart disease ___hypertension ___stroke ___high cholesterol

- **Gastrointestinal:** ___Crohn's ___ colitis ___ulcer ___digestive upset

- **Neurological:** ___ multiple sclerosis ___epilepsy ___Alzheimer's ___Parkinson's ___stroke

- **Constitutional:** ___developmental delay ___weight loss/gain ___fever ___fatigue
- **Genitourinary:** ___STD, viral herpes, Chlamydia ___kidney disease or stones ___bladder disease
- **Psychiatric:** ___depression ___panic disorder ___schizophrenia
- **Ear, Nose, Mouth and Throat:** ___upper respiratory tract infection ___earache ___runny nose ___sore throat ___ringing in ears ___vertigo ___motion sickness
- **Hematologic/Lymphatic:** ___anemia ___bleeding problems ___leukemia
- **Respiratory:** Have you ever smoked? ___yes ___no Do you smoke now? ___yes ___no ___asthma ___bronchitis ___emphysema ___COPD
- **Endocrine:** ___diabetes If yes, do you take insulin? ___ Last Blood Sugar Reading/date/time_____ ____thyroid dysfunction ___hormonal dysfunction ___gallbladder disease
- **Integumentary:** ___eczema ___rosacea ___psoriasis

Please list any other conditions that you have not previously mentioned:

_____

_____

PLEASE SIGN AND DATE BELOW:

Acknowledgement of Receipt of Privacy Practices and Financial Responsibility

I acknowledge that I have received a copy of Provider's Notice of Privacy Practices with the effective date of August 21, 2013 or was presented with a copy of the Privacy Practices and opted not to take a copy.

I understand that I am personally responsible for any fees I will incur with Southerlin Family Eye Care. I am responsible for co-pays and amounts specified by my insurance company. I also understand that I will be responsible for any charges incurred by not providing the most current insurance information. I understand that payment is due at the time of service, and that the amount due in full is required before glasses can be manufactured or contact lenses are ordered. If I purchase products that are taxable under the SC state tax code (including contact lenses, frames and lenses, and optical accessories but not professional services rendered) I am responsible for paying the sales tax on the total cost of products before insurance pays (not on the co-pay).

_____Signature of Patient or Patient's Representative_____Date

If you are unavailable, may we leave medical information, such as reminders about upcoming appointments, the receipt of our office of your glasses or contact lens order, or normal test results on your answering machine or with someone at your residence?

_____YES, you may leave information as above ____NO, do not leave information with anyone