

Welcome to Christie Eye Care

Please answer all questions

Last name _____ First name _____ MI _____
Address _____ City _____ Zip _____
Telephone (W) _____ (H) _____
SSN _____ Date of birth _____
Occupation _____ Sex _____ Marital Status _____
Employer _____

If patient is under 18 years old Parent/Guardian complete this section

Last name _____ First name _____ MI _____
Address _____ City _____ Zip _____
Telephone (W) _____ (H) _____
SSN _____ Date of birth _____
Occupation _____ Sex _____ Marital Status _____
Employer _____
Emergency contact/Telephone number _____
Date of last eye exam _____ Dilated? _____ Today's date _____

MEDICAL INFORMATION

Do you have problems with any of these systems? *(please circle all that apply)*

Gastrointestinal	Y/N	Nervous	Y/N	Mental	Y/N
Ears/Nose/Throat	Y/N	Genitourinary	Y/N	Endocrine (glands)	Y/N
Cardiovascular	Y/N	Musculoskeletal	Y/N	Blood/lymph	Y/N
Respiratory	Y/N	Integumentary (skin)	Y/N	Allergic/immunologic	Y/N

Please Explain _____

Diabetes? Y/N Type _____ Date of diagnosis _____
Allergies? Y/N Allergic to what? _____ What happens? _____
Medication allergy? Y/N What happens? _____
Other health problems _____
Current medication(s) _____
Have you had any operations? Y/N Kind? _____ When? _____
Do you use cigarettes/tobacco? _____ Alcohol? _____ Other substance(s) ? _____
Name of family doctor _____ Date of last visit _____
Date of last tetanus shot _____

FAMILY HISTORY

High blood pressure? Y/N Relation _____	Macular degeneration? Y/N Relation _____
Diabetes? Y/N Relation _____	Retinal detachment? Y/N Relation _____
Glaucoma? Y/N Relation _____	Cataracts? Y/N Relation _____

PERSONAL EYE INFORMATION

Other eye condition(s)	Y/N	What Kind _____	Date _____
Have you had any eye operations	Y/N	Type _____	Date _____
Have you had an eye injury?	Y/N	Kind _____	Date _____
Do you have glaucoma?	Y/N	Cataracts? Y/N Dry eyes? Y/N	Blurred vision? Y/N
Other eye problems?	Y/N	What kind? _____	
Do you wear glasses?	Y/N	Contact lenses? Y/N Type _____	
Additional information _____			
Whom may we thank for referring you? _____			

Doctor's initials _____

- I consent to treatment necessary for the care of the above named patient.
- I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.
- I allow fax transmittal of my medical records, if necessary.
- I acknowledge full financial responsibility for services rendered.
- I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
- I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.
- I further authorize and request that insurance payments be made directly to **Christie Eye Care** should they elect to receive such payment.
- I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

Patient Signature

Date

Parent/Guardian Signature

Parent/Guardian (Print Name)