YANCEY EYE CENTER

Welcome Back to Our Office

Welcome to Yancey Eye Center. Thank you for choosing us for your eye care 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. If you have any questions, please don't hesitate to ask.

□ Mr. □ Miss □ Mrs. □ Ms.

First Name ____ MI ____ Last Name ____ Preferred Name ____

Street Address ____ City ____ State ____ Zip ____

Social Security Number ____ Date of Birth ____ Home Phone ____ Cell Phone ____ Work Phone ____

Email Address ____ Guardian ____ Person Responsible for Account ____

Emergency Contact ____ Emergency Phone ____

How were you referred to our office?

□ Phone Book □ School □ TV □ Patient
□ Insurance Listing □ Drive By □ Radio □ 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 ____ Last Name ____

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

Patient's Relationship to Insured
□ Self □ Spouse □ Child □ Other

Patient's Status (Check all that apply)
□ Single □ Married □ Other □ Full Time Student □ Part Time Student □ Employed

SECONDAY INSURANCE INFORMATION

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

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

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

Patient's Relationship to Insured
□ Self □ Spouse □ Child □ Other

Patient's Status (Check all that apply)
□ Single □ Married □ Other □ Full Time Student □ Part Time Student □ Employed

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. 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 Yancey Eye Center. I understand that my vision plan will be billed as my primary insurance. I understand that billing any secondary vision plan 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 ____

YANCEY EYE CENTER
PATIENT HISTORY AND INFORMATION

Name: ____

Race:

□ American Indian or Alaska Native
□ Asian
□ Black or African American
□ Hispanic or Latino
□ Native Hawaiian or Other Pacific Islander
□ White
□ Declined to Specify
□ Other Race ________________________

Ethnicity:

□ Hispanic or Latino □ Not Hispanic or Latino □ Declined to Specify

Preferred Language:

□ English □ Chinese □ Dutch; Flemish □ French □ German □ Hindi □ Spanish □ Other ________________

Height: ____ ft. ____ in. ____ cm/m Weight: _____ lbs./kg.

PRIMARY CARE PHYSICIAN

____

Primary Care Physician and Clinic Name

____

Address of Primary Care Physician City State Phone

REFERRING PHYSICIAN

____

Referring Physician and Clinic Name

____

Address of Referring Physician City State Phone

HEALTH HISTORY

What is the main reason for today's exam: ____

When was your last vision exam?: __________________________ When was your last health exam?: ______________________________

Past illnesses or Injuries: ______________________________________ ______________________________________

______________________________________ ______________________________________

Past Surgeries: ______________________________________ ______________________________________

______________________________________ ______________________________________

Current Medications:
(Provide a List) ______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

Current Eye Drops: ______________________________________ ______________________________________

ALLERGIES:

Are you allergic to any medications: □ YES □ NO If yes, please list: ____

____

____

____ ____

Signature Date

YANCEY EYE CENTER
PATIENT HISTORY AND INFORMATION

Name: ____

PERSONAL EYE HISTORY

□ Yes □ No Glaucoma	□ Yes □ No Dryness	□ Yes □ No Strabismus (Crossed Eyes)
□ Yes □ No Cataract	□ Yes □ No Excess Tearing/Watering	□ 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 or 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 Droopy 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 or Gritty Feeling	

PERSONAL HEALTH CONDITION

□ Yes □ No 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 Muscles, Bones, Joints	□ Yes □ No Allergic
□ Yes □ No Cardiovascular (high blood pressure, etc.)	□ Yes □ No Skin	□ Yes □ No Pregnant
	□ Yes □ No Neurological (MS)	□ Yes □ No Nursing

FAMILY HISTORY (MOTHER, FATHER, BROTHER, SISTER)

□ Yes □ No 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

SOCIAL HISTORY

Current Occupation: ________________________ Years ______ Employer ____________________________

SPECTACLE LENS HISTORY

Do you use a computer? □ Yes □ No

Do you have glare problems? □ Yes □ No

Do you wear sunglasses? □ Yes □ No

PERSONAL 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 per day □ 4+/ per day

Do you smoke: □ Yes □ No If yes, how much/often? □ Occasional □ ½ pack/day □ 1 pack/day □ 1+ pack/day

Smoking Status: Method of Tobacco Intake: □ Smoking □ Chewing

Do you use illegal drugs: □ Yes □ No

Hobbies/Interests: ____

____ ____________________________

Signature Date