

**WELCOME**  
Patient Information

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

Phone Numbers:(Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Cell): \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

(If applicable)SPOUSE'S NAME: \_\_\_\_\_ Phone number: \_\_\_\_\_

(If a minor) PARENT'S NAME: \_\_\_\_\_ PARENT'S SS#: \_\_\_\_\_

PERSON TO CONTACT IN CASE OF EMERGENCY: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_

## AUTHORIZATION

I authorize David S. Hill, O.D. to perform diagnostic procedures and treatment as may be necessary for proper vision care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another Optometrist or M.D. I may be referred to.

I hereby authorize payment of insurance benefits directly to the doctor or practice, otherwise payable to me.

I understand that my vision/medical care insurance carrier or payer of my vision/medical benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by vision/medical care payor.

I attest to the accuracy of the information on this page.

I acknowledge that I have read a copy of David S. Hill, O.D., P.A.'s Notice of Privacy Practices.

Signature \_\_\_\_\_

Date: \_\_\_\_\_

Print Name \_\_\_\_\_

## INSURANCE INFORMATION

If you have insurance coverage, **Remember to bring your Insurance Card with you, Including Medicare and Medicaid Cards,** so we may place a copy of them in your record!

**Please Note! We are unable to see Medicaid patients if you do not bring your valid North**

**Carolina Medicaid card with you to your appointment!**

**SELF PAY:** (NO INSURANCE) I personally will be paying for my examination and any optical goods purchased. YES or NO

**PRIMARY INSURANCE:** (Your Major Medical Health Insurance will cover for diagnosis and treatment of eye injuries, illnesses, and diseases.) YES or NO

**SECONDARY INSURANCE:** (These include Medicare Supplemental Insurance Policies as well as Medicaid coverage in addition to Medicare!) YES or NO

**DO YOU HAVE A POLICY THAT COVERS OR IS SPECIFICALLY FOR “ROUTINE” VISION CARE?** (Typically, policies that have this will state either “Routine Eye Examination Coverage or Optical Coverage) YES or NO

## INSURANCE SIGNATURE ON FILE

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Dr. David Hill, OD on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the CMS-150 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurance or agency shown, and authorizes my doctor to act as my agent, as above.

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Lifetime Patient Signature

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Date



## Patient's Ocular History

Please list any injuries, surgeries, or hospitalizations that you have had regarding your eyes:

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Do you have any to the following eye problems: (please check all that apply)

<input type="checkbox"/>	Crossed Eyes	<input type="checkbox"/>	Organic	<input type="checkbox"/>	Droopy Eyelids
<input type="checkbox"/>	Bulging Eyes	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Retinal Disease
<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	Eye Infections	<input type="checkbox"/>	Eye Injury _____
<input type="checkbox"/>	Loss of Vision	<input type="checkbox"/>	Blurred Vision	<input type="checkbox"/>	Distorted Vision
<input type="checkbox"/>	Loss of Side Vision	<input type="checkbox"/>	Double Vision	<input type="checkbox"/>	Dryness
<input type="checkbox"/>	Mucous Discharge	<input type="checkbox"/>	Redness	<input type="checkbox"/>	Gritty Feeling
<input type="checkbox"/>	Itching	<input type="checkbox"/>	Foreign Body Sensation	<input type="checkbox"/>	Excess Tearing/Watering
<input type="checkbox"/>	Glare/Light Sensitivity	<input type="checkbox"/>	Eye pain or soreness	<input type="checkbox"/>	Chronic Infection of Eye
<input type="checkbox"/>	Stys or Chalazion	<input type="checkbox"/>	Flashes/Floaters in Vision	<input type="checkbox"/>	Tired Eyes
<input type="checkbox"/>	Amblyopia (Lazy Eye)	<input type="checkbox"/> OD	<input type="checkbox"/> OS	<input type="checkbox"/> OU	<input type="checkbox"/> Refractive
				<input type="checkbox"/>	Strabismus(Crossed/Wondering Eyes)

## Glasses/Contacts

### Glasses:

Do you wear glasses?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, how old is your present pair of lenses?	_____ Years	Other: _____.

### Contacts:

Do you wear contact lenses?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, how old is your present pair of lenses?	_____ Years	Other: _____.
Type of Contact Lenses	<input type="checkbox"/> Rigid	<input type="checkbox"/> Soft
		<input type="checkbox"/> Extended Wear
		Other: _____.
Are they comfortable?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

## Patient's Medical History

Please Check all that apply regarding your personal health

<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	HTN	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	Thyroid Disease

Other: \_\_\_\_\_

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### **Family Ocular History**

Please check all that apply regarding your immediate family:

<input type="checkbox"/> Relationship: _____	Blindness	<input type="checkbox"/> Relationship: _____	Macular Degeneration
<input type="checkbox"/> Relationship: _____	Cataracts	<input type="checkbox"/> Relationship: _____	Retinal Detachment/Disease
<input type="checkbox"/> Relationship: _____	Crossed Eye	<input type="checkbox"/> Relationship: _____	Amblyopia
<input type="checkbox"/> Relationship: _____	Glaucoma		

### **Family Medical History**

Please check all that apply regarding your immediate family:

<input type="checkbox"/> Relationship: _____	Arthritis	<input type="checkbox"/> Relationship: _____	High Blood Pressure
<input type="checkbox"/> Relationship: _____	Cancer	<input type="checkbox"/> Relationship: _____	Kidney Disease
<input type="checkbox"/> Relationship: _____	Diabetes	<input type="checkbox"/> Relationship: _____	Lupus
<input type="checkbox"/> Relationship: _____	Heart Disease	<input type="checkbox"/> Relationship: _____	Thyroid Disease

Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Review of Systems

(Please: check all the apply)

**Constitutional**  None

<input type="checkbox"/> Fever	<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Skin
<input type="checkbox"/> Polydipsia	<input type="checkbox"/> Polyuria	<input type="checkbox"/> Polyphagia	

**Integumentary**  None

<input type="checkbox"/> Skin Problems
Other: _____.

**Endrocrin**  None

<input type="checkbox"/> Skin Problems
Other: _____.

**Neurological**  None

<input type="checkbox"/> Headaches	<input type="checkbox"/> Migraines	<input type="checkbox"/> Seizures	
<input type="checkbox"/> CVA	<input type="checkbox"/> TIA	<input type="checkbox"/> Oph. Migraines	Other: _____.

**Ear, Nose, Mouth Throat**  None

<input type="checkbox"/> Allergies/Hay Fever	<input type="checkbox"/> Sinus Congestion	<input type="checkbox"/> Runny Nose	
<input type="checkbox"/> Post-nasal Drip	<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Dry Throat/Mouth	Other: _____.

**Respiratory**  None

<input type="checkbox"/> Asthma	<input type="checkbox"/> Chronic Bronchitis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> COPD
Other: _____.			

**Vascular/Cardiovascular**  None

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heat Pain	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Vascular Disease
<input type="checkbox"/> MI	<input type="checkbox"/> Bypass Surgery	<input type="checkbox"/> PAD	<input type="checkbox"/> Carotid Disease
Other: _____.			

**Gastrointestinal**  None

<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Constipation	Other: _____.
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**Bones, Joints, Muscles**  None

<input type="checkbox"/> Rheumatoid	<input type="checkbox"/> Muscle Pain	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Osteo Arthritis
Other: _____.			

**Emotional/Psychological**  None

<input type="checkbox"/> Psychological	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other: : _____.		

**Allergic/Immunologic**  None

<input type="checkbox"/> Allergic	<input type="checkbox"/> Immunologic	<input type="checkbox"/> Atopic
Other: : _____.		

**Lymphatic/Hematologic**

None

<input type="checkbox"/> Anemia	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Clotting Disorder
Other: _____.		

**Social History**

Yes, I would prefer to discuss my Social history directly with my doctor.

Do you drive?  Yes  No  
 If yes, do you have vision difficulty when driving  Yes  No

Please Describe: \_\_\_\_\_

Tobaco Use  Never  In Past  Currently  
 If yes, select types  Cigarettes  Cigars  Chew  Dip  Pipe

How often / How much? \_\_\_\_\_

When did you start? \_\_\_\_\_

When did you stop? \_\_\_\_\_

Alcohol Use  Never  In Past  Currently  
 If yes, select type  Beer  Liquor  Wine

If yes, describe typical amount? \_\_\_\_\_

If in past, when did you stop? \_\_\_\_\_

Illicit Drug Use:  Never  In Past  Currently

If yes, what type? \_\_\_\_\_

If yes, describe typical amount? \_\_\_\_\_

If in past, when did you stop? \_\_\_\_\_

Have you ever been exposed to or infected with  Gonorrhea  Hepatitis  HIV  Syphillis