

WELCOME!

Thank you for choosing LORD EYE CENTER for your eye care needs. Please complete the following pages in **ink**. If you have any questions, do not hesitate to ask for assistance. We are happy to help.

Dr. Mr. Mrs. Miss Ms.

Name: _____ Sr. Jr. III
First M.I. Last

Date of Birth: _____ SS#: _____ Male Female

Address: _____
Street

City State Zip

Home ph: _____ (Same as home) Cell ph: _____

Work ph: _____

Email: _____

Marital Status: Single Married Widowed Minor (Single)

Employment Status: Employed Not Employed Self-Employed Student Retired

Emergency Contact: _____ Phone: _____

Lord Eye Center may discuss patient's medical findings with the above named contact, (only if necessary).

Payment Method

I understand that payment for all charges incurred today is to be paid *in full* at check-out. I will pay with:

Cash Credit/Debit Card Check

Signed: _____ Date: _____
Patient/Guardian

Parent/Guardian Information: N/A Check here if same as Patient and Skip to Insurance

Name: _____ Relationship to patient: _____

Date of Birth: _____ SS#: _____

Address: _____
Street City State Zip

Home ph: _____ (Same as home) Cell ph: _____

Insurance

Medical Carrier: _____ Member: _____ Same as Patient

Member DOB: _____ ID/SS #: _____ Group # _____

Does this policy include routine vision coverage? YES NO (Supply separate vision insurance below)

Vision Carrier: _____ Member: _____ Same as Patient

Member DOB: _____ ID /SS#: _____ Group # _____

Medicare Members Only: Supplemental coverage? Yes (Fill in below) NO Medicaid

Insurance Name: _____ Policy Number _____

Medical History

Drug Allergies: _____

Current Medications being taken: _____

Conditions currently being treated: _____

Do you currently have, or have you ever had, any problems in the following areas?

Disease/Condition	NO	YES	Disease/Condition	NO	YES
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Discharge from the Eye	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Redness	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	Burning	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	Object in the Eye	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Eye Infection	<input type="checkbox"/>	<input type="checkbox"/>
Eye Dryness	<input type="checkbox"/>	<input type="checkbox"/>	Spots in the Eye/Floaters	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/Gland Problems	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>

Anything else you feel your doctor should know about today:

Please check any of the following YOU have had:

Glaucoma Retinal Disease Cataracts

Eye Injury →What happened? _____

When? _____

Are you currently nursing or pregnant? Yes No N/A

Family History

Please note family history (parents, grandparents, siblings, children) for the following conditions:

Disease/Condition	NO	YES	Relationship(s) to YOU
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above question have been answered accurately. I authorize Lord Eye Center to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eye care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the doctor or ophthalmic group insurance benefits otherwise payable to me, unless my insurance is not accepted at this location. I understand that my insurance may pay less than the actual bill for services. I agree to be responsible for the payment of all services rendered on my behalf or my dependents.

Printed Name: _____ Date: _____

Signed: _____