Cambridge Family Eyecare, Inc.
1335 Southgate Parkway
Cambridge, Ohio 43725

PATIENT INFORMATION

Circle one
Name Mr. Mrs. Miss ______________________________
Last First Int.

Address ______________________ Birth date ______________________

______________________ Check Box: Male ☐ Female ☐

Home Phone # ______________________ S.S. # ______________________

Work Phone # ______________________

Place of Employment ______________________

Name of Spouse or Parent ______________________

VISION INSURANCE INFORMATION

Primary	Secondary
Plan Name ______________	Plan Name ______________
Address ______________	Address ______________
______________	______________
Insured Name ______________	Insured Name ______________
Insured DOB ______________	Insured DOB ______________
Member ID# ______________	Member ID# ______________
SS# ______________	SS# ______________
Patient's Relationship to Insured ______________	Patient's Relationship to Insured ______________

Please Read and Sign ______________________________

1. I authorize the release of any information pertinent to my claim to my insurance company.
2. Insurance coverage is considered a method of reimbursing the patient for fees paid to the physician and is not a substitute for payment. Some insurance companies pay a fixed fee for procedures and services, and other insurance companies pay a percentage of the charge.
3. It is your responsibility to pay for all charges and services rendered REGARDLESS of insurance coverage.
4. In order to control the cost of billings, we request that all charges for goods and services be paid at the conclusion of each visit.
5. Deductibles and co-payments are due today.
6. The patient or whomever brings the patient into the office is responsible for payment of fees.

MEDICAL HISTORY QUESTIONNAIRE

Name ____ Date ______________________

Date of Birth________________ Date of Last Eye Exam________________

List any medications you currently take (prescription and over-the-counter):

____

____

Do you have allergies to any medications? ☐ YES ☐ NO If YES, list the medications:__________

____

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.):

____

____

List any surgeries you have had (cataract, tonsillectomy, appendectomy):

____

____

Do you *currently* have any problems in the following areas? If "YES", please provide information.

	YES	NO	Explanation of Problem
EYES (Glaucoma, cataract, retinal disease, etc.)			
Loss of vision			
Blurred vision			
Distorted vision (halos)			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing/watering			
Glare/light sensitivity			
Eye pain or soreness			
Infection of eye or lid (blepharitis, stye)			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			
GENERAL/CONSTITUTIONAL			
Fever			
Weight loss			
Other			
EARS, NOSE, THROAT (Sinus, ear infection, chronic cough, dry mouth etc.)			

PLEASE TURN OVER AND COMPLETE OTHER SIDE

CARDIOVASCULAR (Heart, vessels, etc.)			
RESPIRATORY (Asthma, emphysema, etc.)			
GASTROINTESTIONAL (Stomach ulcers, intestinal disease, etc.)			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS (Arthritis, etc.)			
SKIN (Acne, warts, skin cancer, etc.)			
NEUROLOGICAL (Multiple sclerosis, etc.)			
PSYCHIARTRIC (Anxiety, depression, insomnia)			
ENDOCRINE (Diabetes, hypothyroid, etc.)			
BLOOD/LYMPH (Cholesterolemia, anemia, etc.)			
ALLERGIC/IMMUNOLOGIC (Hay fever, lupus, Sjogrens, etc.)			

FAMILY HISTORY

M = mother F = father S = sibling GP = grandparent

DISEASE	YES	NO	RELATIONSHIP TO PATIENT
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Other			

SOCIAL HISTORY

Current occupation:____________________

Education (high school, vocational school, college degree):____________________

Marital Status (married, divorced, single, widowed):____________________

Do you drive? ☐ YES ☐ NO

Do you have visual difficulty when driving? ☐ YES ☐ NO

Do you have problems with night vision? ☐ YES ☐ NO

Have you ever tried to wear contact lenses? ☐ YES ☐ NO

Do you currently wear contact lenses? ☐ YES ☐ NO

If YES, how long have you worn contact lenses?____________________

Do you currently wear glasses? ☐ YES ☐ NO

If YES, how long have you had the current prescription?____________________

Do you drink alcohol? ☐ YES ☐ NO If YES: occasional 1 per day 2-3 / day 4+ / day

Do you smoke? ☐ YES ☐ NO If YES: occasional ½ pack/day 1 pack/day 1+ pack

Have you ever had a blood transfusion? ☐ YES ☐ NO

History reviewed. ☐ No Changes. ☐ Additions as noted above.

Physician's Signature:____________________ Date __________