Patient No. _____

Today's Date_____

Eastland Eye Care Associates

Brian D. Tipton O.D.
Aaron M. Scavezze O.D.

Mr Mrs Ms

Last name_____First name_____MI_____Birthdate_____Age_____

Address_____City_____State_____Zip_____

Telephone (home)_____(work)_____

SSN_____Sex M / F Marital Status: [] Single [] Married [] Widowed [] Separated [] Divorced

Occupation_____Employer_____

Name of person responsible for account_____Relationship_____

Responsible party's address_____City_____State_____Zip_____

Emergency contact/Telephone number_____

Method of payment [] Check [] Cash [] Charge [] Insurance

MEDICAL INFORMATION

How is your overall health?_____

Do you have any problems with any of these systems?

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_____

Other health problems_____

Please answer the following:

Hypertension Y / N

Diabetes Y / N Type_____Date of diagnosis_____

Allergies Y / N Allergic to what?_____What happens?_____

Medication allergy Y / N To what?_____Headaches Y / N

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_____

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_____
Other eye condition(s)	Y / N	What kind?_____			Relation_____

PERSONAL EYE INFORMATION

Have you had any eye operations? Y / N Type_____Date_____

Have you had an eye injury? Y / N Type_____Date_____

Do you have:

Glaucoma	Y / N	Cataracts	Y / N	Dry eyes	Y / N	Blurred vision	Y / N
Double vision	Y / N	Flashes of light	Y / N	Floaters/spots	Y / N	Eyes burn/itch/water	Y / N
Lazy/turned eye	Y / N	Sensitivity to light	Y/ N	Poor distance vision	Y / N	Poor near vision	Y / N

Other eye problems Y / N What kind?_____

Do you wear glasses? Y / N [] Full time [] Part time [] Distance only [] Reading only [] Other_____

Have you ever worn contact lenses before? Y / N What kind?_____For how long?_____

Are you interested in: Contact lenses? Y / N Laser Vision Correction? Y / N

Do you work at a computer or VDT? Y / N What hobbies or sports do you play?_____

Date of last eye exam_____Doctor's name_____Referrred by_____

AOR ☐ Refused AOR ☐ Office use only Doctor's initials_____

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Brian D. Tipton OD and Aaron M Scavezze OD's Notice of Privacy Practices.

Patient name_____

Signature_____Date_____

Insurance Information

Name of insured_____ID#_____Relation to patient_____

Address of insured_____City_____State_____Zip_____-____

Date of birth of insured_____SSN_____Employer_____

Insurance company name_____Insurance company phone #_____

Authorization

I authorize the release of any information necessary to my insurance company in order to process claims on my (or my dependents) behalf. I authorize payment of insurance benefits directly to Eastland Eye Care Associates. I understand and agree that regardless of my insurance payment status, I am ultimately responsible for any balance on this account for any professional services and/or materials received by me or my dependents.

Signature of patient (or parent if a minor) Date