Bay Eye Care Center

PATIENT DEMOGRAPHIC INFORMATION

Full legal name: **Date**________________________

Last Name ____________________________ First Name _________________________ M.I. ____________

Nickname _____________________________ Previous Last Name ___________________________________

Social Security # ______________________________

Birth date ___________________ Age ____________ Gender ☐ Male ☐ Female

Address ____________________________________ City ______________________________________

State _____________________________ Zip Code ________ County__________________________

2nd Address ____________________________________ City __________________________________

State _____________________________ Zip Code ________ County__________________________

Race: ☐ White ☐ African American ☐ Hispanic ☐ Indian ☐ Multi-racial
☐ Native American ☐ Other Race ☐ Not Reported

Language: ☐ English ☐ Spanish ☐ Hindi ☐ Polish ☐ Japanese
☐ Sign Language ☐ Other____________________________

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown or Not reported

Marital Status: ☐ Married ☐ Divorced ☐ Legally Separated ☐ Single ☐ Widowed

Referred by:

☐ Family Physician / Another Doctor________________________ ☐ Another Patient___________________

☐ Optometrist____________________________ ☐ McLaren Bay Region ☐ Mid Michigan Medical Center

☐ West Branch Medical Center

How did you hear about us? ☐ Employee ☐ Expo ☐ Helen Nickless Volunteer Clinic ☐ Newspaper
☐ Internet ☐ Yellow Pages

Primary Care Provider____ Phone#________________________

Student Status: ☐ Full-Time ☐ Part-Time ☐ Not a Student

Phone:

Home Phone_______________________ Cell Phone_____________________ Alt. Phone________________

Day Phone________________________________Email____

Employer Name____Work Phone______________________

Employer Address____

Employment Status: ☐Full Time ☐Part Time ☐Not Employed ☐Active Duty ☐Retired ☐Self-Employed

Spouse Information:
Last Name__________ First Name__________ M.I.____
Social Security #__________ Birth date__________

Responsible Party (if other than patient):
Last Name__________ First Name__________ M.I.____
Social Security #__________ Birth date__________
Address__________ City__________ State______ Zip Code ______
Relationship__________

If dependant (under the age of 18):
Name of Father__________ Employer__________
Address __________ Phone__________
Name of Mother__________ Employer__________
Address __________ Phone__________

Emergency Contact Name__________ Relationship __________
Home Phone __________ Cell Phone __________Work Phone __________
Address__________

Insurance Information: Please note your Insurance card and picture ID will also be copied
Medical Insurance company: __________
Name of Insured (Name on Card) __________
Contract # __________ Group # __________ SSN # __________
Birth date of Insured: __________ Relationship to Patient __________

Secondary Insurance company: __________
Name of Insured (Name on Card) __________
Contract # __________ Group # __________ SSN # __________
Birth date of Insured: __________ Relationship to Patient __________

Primary Vision Insurance company: __________
Name of Insured (Name on Card) __________
Contract # __________ Group # __________ SSN # __________
Birth date of Insured: __________ Relationship to Patient __________

Secondary Vision Insurance company: __________
Name of Insured (Name on Card) __________
Contract # __________ Group # __________ SSN # __________
Birth date of Insured: __________ Relationship to Patient __________

Financial assignment and agreement:

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the Doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.**
2. **In order to control your cost of billing, we request that your charges for office visits be paid at the conclusion of each visit unless you are covered by Medicare.**
3. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid, it agents, or any insurance carrier I may have, any information needed to determine these benefits or benefits payable for related services.
4. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all the charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

____ ______________________

Signature of Patient/Legal Guardian **Date**

I authorize the practice to leave messages on my answering machine/voice mail: ☐YES ☐NO
I authorize the release of my protected health information over the telephone or in person to the following individuals:

Name of Person:__________________________________Relationship:________________
Home Phone:____________________________________Work Phone:________________
Cell Phone:______________________________________

Name of Person:__________________________________Relationship:________________
Home Phone:____________________________________Work Phone:________________
Cell Phone:______________________________________

Name of Person:__________________________________Relationship:________________
Home Phone:____________________________________Work Phone:________________
Cell Phone:______________________________________

Patient/Guardian Signature:________________________ **Date:**______________

Witness Signature:______________________________ **Date:**______________

BAY EYE CARE CENTER
PATIENT HEALTH AND HISTORY FORM

Today's Date:________________

Patient Name:____ Date of Birth:______________

Eye Symptoms – Do you (the patient) experience any of the following?

- ❑ Blurred vision
- ❑ Distorted vision
- ❑ Double vision
- ❑ Missing vision
- ❑ Red eyes
- ❑ Burning eyes
- ❑ Itchy eyes
- ❑ Dry eyes
- ❑ Watery eyes
- ❑ Gritty or sandy eyes
- ❑ Discharge from eyes
- ❑ Aching eyes
- ❑ Flashing lights
- ❑ Floating spots
- ❑ Drawing or Pulling
- ❑ Painful eyes
- ❑ Seeing rings around lights
- ❑ Night vision problems
- ❑ Depth perception problems
- ❑ Excessive squinting

❑ Other:____

Do you wear?

Glasses ❑ No ❑ Yes If Yes, how old is the prescription?__________

Contact Lens ❑ No ❑ Yes If Yes, how old is the prescription?__________ Soft / Gas Perm - What brand of contacts?_____________

Please list any current **eye medications** (*with dosage)* you are taking *(include any over-the-counter supplements and drops)*:

______________________________ ______________________________

______________________________ ______________________________

Please list any **other medications** you are taking including supplements or vitamins. Or, provide a detailed list.

____

____

____

____

Please list any drug or food allergies:____

____

Review of Systems – Do you (the patient) currently experience problems in the following areas today?

CONSTITUTIONAL: (General Health)

No	Yes	
❑	❑	Fatigue
❑	❑	Fever
❑	❑	Weight gain/ loss
❑	❑	Other: ______________

HEENT: (Ears, Nose, Throat)

No	Yes	
❑	❑	Hearing loss
❑	❑	Sinus problems
❑	❑	Sore throat
❑	❑	Other: ______________

RESPIRATORY: (Breathing, Lungs)

No	Yes	
❑	❑	Asthma
❑	❑	Cough
❑	❑	Wheezing
❑	❑	TB exposure
❑	❑	Other: ______________

CARDIOVASCULAR: (Heart)

No	Yes	
❑	❑	Chest pressure or discomfort
❑	❑	Irregular heartbeat / palpitations
❑	❑	Other: ______________

GASTROINTESTINAL: (Stomach)

No	Yes	
❑	❑	Abdominal pain
❑	❑	Diarrhea
❑	❑	Heartburn
❑	❑	Vomiting
❑	❑	Other: ______________

NEUROLOGICAL: (Nervous System)

No	Yes	
❑	❑	Balance disturbances
❑	❑	Dizziness
❑	❑	Headaches
❑	❑	Memory loss
❑	❑	Seizures
❑	❑	Other: ______________

PSYCHIATRIC: (Mental Health)

No	Yes	
❑	❑	Depression
❑	❑	Panic Disorder
❑	❑	Schizophrenia
❑	❑	Stress
❑	❑	Claustrophobia
❑	❑	Other:______________

INTEGUMENTARY: (Skin)

No	Yes	
❑	❑	Dry Skin
❑	❑	Rashes
❑	❑	Other: ______________

MUSCULOSKELETAL: (Bones, Muscles)

No	Yes	
❑	❑	Back pain
❑	❑	Joint Swelling
❑	❑	Muscle weakness
❑	❑	Arthritis
❑	❑	Other:______________

HEMATOLOGIC: (Blood)

No	Yes	
❑	❑	Bleeding
❑	❑	Bruising
❑	❑	Other:______________

IMMUNOLOGIC: (Allergies)

No	Yes	
❑	❑	Environmental allergies
❑	❑	Food allergies
❑	❑	Seasonal allergies / Hayfever
❑	❑	Latex allergy
❑	❑	Other: ______________

BAY EYE CARE CENTER
PATIENT HEALTH AND HISTORY FORM

Eye History – Do you have or have you had any of the following:

- ❑ Cataract / Cataract surgery
- ❑ Glaucoma / Glaucoma Surgery
- ❑ Neurological problems (e.g. Nerve palsy, Bell's Palsy)
- ❑ Retinal problems (e.g. macular degeneration, retinal detachment, diabetes)
- ❑ Corneal injuries or surgeries (e.g. corneal abrasion, metal in the eye, corrective eye surgery, corneal transplant)
- ❑ Kerato-refractive (e.g. glasses, contacts, lazy eye, patching of an eye)
- ❑ Oculoplastic (e.g. eyelid surgery, bumps on lids, droopy lids, cancer)
- ❑ Strabismus (e.g. crossed eyes, wandering eye, double vision, eye muscle surgery)

❑ None of the above ❑ Other:____________________

Please list any eye surgeries and dates if possible: ____________________

____

Health History – Are you treating or have you been treated for any of the following?

❑ Arthritis	❑ GERD	❑ Kidney Disease
❑ Blood Clots	❑ Heart Disease	❑ Lupus
❑ Cancer - If yes, where __________	❑ High Blood Pressure	❑ Rheumatoid Arthritis
	❑ High Cholesterol	❑ Sjogren's Disease
❑ Coronary Artery Disease	❑ HIV / Hepatitis	❑ Stroke
❑ Diabetes (Type 1 or Type 2)		❑ Thyroid Disease / Grave's Disease

❑ None of the above ❑ Other:____________________

Please list any surgeries and dates if possible:____________________

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Social History - (This information is kept strictly confidential. This applies to patients 13 years and older)

Have you ever used tobacco? ❑ No / Never ❑ Yes If yes, ❑ Current ❑ Former Use, ❑ Light ❑ Heavy

Do you drink alcohol? ❑ No ❑ Yes Do you consume caffeine? ❑ No ❑ Yes

Family History - Has anyone in the patient's family (blood relative) had any of the following?

❑ Unknown-Adopted	❑ Color Blindness	❑ Diabetes	❑ Lazy Eye (Amblyopia)
❑ Blindness	❑ Corneal Disease	❑ Glaucoma	❑ Macular Degeneration
❑ Cancer	❑ Crossed Eyes (Strabismus)	❑ Heart Disease	❑ Retinal Disease
❑ Childhood Cataracts		❑ High Blood Pressure	

Medication History Consent - (This permission will expire after 3 years)

Through our Electronic Health Record System, Bay Eye Care Center is able to download the history of medications you have had filled at participating retail pharmacies over the prior year. We would provide that service for you, if you and your doctor agree.

I give permission to download my prescription medication history. No Yes

Preferred Local Pharmacy____________________ City and Cross Streets____________________

Preferred Mail-Order Pharmacy____________________ Signature____________________

The information provided is true and complete to the best of my knowledge

____________________ ____________________
Patient Signature (Guardian If Patient Is A Minor) Date

____________________ ____________________
Name Of Person Completing Form (If Not Patient) Relationship To Patient