Welcome to Liberty EyeCare

Please fill out this form completely. The better we communicate, the better we can care for you.

First Name: _____ M: _____ Last Name: _____ I prefer to be called: _____

Address: _____City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Gender: M F SS#: _____Email: _____

Marital Status: ☐ Single ☐ Married ☐ Other Ethnicity (optional): _____ Race (optional): _____

Preferred Language: _____Employer/School: _____ Occupation/Grade: _____

Hobbies: _____

Communication Preference: (email phone text postal)

Whom may we thank for referring you to our office? _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Physician: _____ Last medical exam: _____ Last eye exam: _____ Where: _____

INSURANCE INFORMATION

Vision Insurance: _____ ID #: _____

Medical Insurance: _____ ID #: _____

Subscriber Name: _____ Relationship to Patient: _____ Date of Birth: _____

PERSONAL MEDICAL HISTORY

MAIN REASON FOR VISIT: _____

Medications (including eye drops, birth control pills, vitamins and over-the-counter medications): _____

_____

Allergies: ☐ No ☐ Yes ☐ No known medication allergies Please list: _____

☐ No ☐Yes **General** (Cancer, Developmental Disability, Trauma, Loss of Blood) Other: _____

☐ No ☐Yes **Ears/Nose/Mouth/Throat** (Hearing Loss, Sinus) Other: _____

☐ No ☐Yes **Cardiovascular** (High Cholesterol, Stroke, Heart Disease, Hypertension) Other: _____

☐ No ☐Yes **Respiratory** (Asthma, Bronchitis, Emphysema, COPD) Other: _____

☐ No ☐Yes **Gastrointestinal** (Chron's, Colitis, Acid Reflux, Colon Cancer) Other: _____

☐ No ☐Yes **Genitourinary** (bladder cancer, prostate cancer) Other: _____

☐ No ☐Yes **Musculoskeletal** (Osteoarthritis, Fibromyalgia, Muscular Dystrophy, Ankylosing Spondylitis) Other: _____

☐ No ☐Yes **Skin** (Eczema, Rosacea, Psoriasis, Acne) Other: _____

☐ No ☐Yes **Neurological** (Multiple Sclerosis, Epilepsy, Cerebral Palsy, Tumor) Other: _____

☐ No ☐Yes **Psychiatric** (ADHD, Depression, Anxiety, Schizophrenia) Other: _____

☐ No ☐Yes **Endocrine** (Diabetes, Thyroid Disorder, Hormonal Dysfunction) Other: _____

☐ No ☐Yes **Lymphatic/Hematological** (Anemia, Leukemia, Bleeding Disorder) Other: _____

☐ No ☐Yes **Allergic/Immunologic** (Seasonal, HIV/AIDS, Rheumatoid Arthritis, Lupus, Neurofibromatosis) Other: _____

☐ No ☐Yes **Eyes** (Injuries, Surgeries, Glaucoma, Macular Degeneration, Cataracts, Lazy Eye) Other: _____

☐ No ☐Yes **Other** _____

Have you ever had eye surgery? ☐ Yes ☐ No Please List: _____

Do you wear contacts? ☐ Yes ☐ No Type: _____ Are you interested in contacts? ☐Yes ☐No LASIK? ☐Yes ☐NO

Smoking Status: ☐ Current Every Day ☐ Current Some Day ☐ Former ☐ Never

Alcohol Use? ☐ None ☐Social ☐Moderate ☐Excessive Narcotic/Drug Use? ☐None ☐Social ☐Dependence

Are you currently pregnant or nursing? ☐ Yes ☐No

EYE HISTORY

Are you currently or have you ever experienced any of the following problems?

☐ Blurred Vision	☐ Double Vision	☐ Eye Strain	☐ Eye Pain	☐ Burning Eyes
☐ Itching Eyes	☐ Dry Eyes	☐Red Eyes	☐ Watery Eyes	☐ Light Sensitivity
☐ Floaters	☐Flashes	☐ Headaches/Migraines	☐ Loss of Vision	☐ Crossed Eyes
☐ Poor Night Vision	☐ Poor Color Vision	☐ Droopy Eyelid	☐ Other: _____	

FAMILY HISTORY

Has anyone in your family (grandparents, siblings, children) been diagnosed with the following:

☐ Cataract	☐Glaucoma	☐ Macular Degeneration	☐ Retinal Detachment	☐ Blindness
☐ Diabetes	☐ High Blood Pressure	☐ High Cholesterol	☐ Cancer	☐ Thyroid Condition

IF PATIENT IS **18 OR UNDER**, PLEASE COMPLETE:

Any complications during pregnancy or birth? ☐ Yes ☐ No _____

Any developmental delays? ☐ Yes ☐ No _____

Do you have concerns with your child's school performance? ☐ Yes ☐ No _____

FINANCIAL RESPONSIBILITY & INSURANCE AUTHORIZATION

Liberty EyeCare will file insurance claims for all insurance companies with whom we have an active contract with. If we are an out-of-network provider for your insurance plan, we will provide you will all necessary paperwork, which you may submit to your insurance carrier for reimbursement. It is your responsibility to know your insurance policy's coverage and limitations. You will be responsible for any portion of fees not covered or not paid by your insurance company.

AUTHORIZATION: I authorize Liberty EyeCare to release any necessary information required for insurance processing. I agree to pay in full at the time of service all copays, deductibles, co-insurances and not covered services as determined by my insurance company.

Patient (legal guardian if under 18):_____ Date: _____

PRIVACY POLICY ACKNOWLEDGEMENT

I acknowledge that I have been offered a copy of the "Notice of Privacy Practices" from Liberty EyeCare.

Patient (legal guardian if under 18):_____ Date: _____

THANK YOU!

Liberty EyeCare is now on Facebook. Become part of our on-line family today for exclusive offers, contests, news and fun eyecare articles and photos.

Like and **Recommend** us on Facebook today!