# Waters Family Eyecare Patient History Form

Last Name: _____ First Name:_____ MI:_____

Address:_____City:_____ST:_____Zip:_____

Phone (C)_____(W)_____(H)_____

Last 4 of SSN:__ __ __ __ DOB: ____/____/____ Primary Medical Insurance /ID#:_____

Primary Vision Insurance name/ ID#_____

Primary Insured Member Information (if other than patient):

Name:_____ Relationship to Patient:_____

Last 4 of SSN:___ ___ ___ ___ Birthdate:____/____/_____ Employer:_____

Last Eye Exam:_____Were you Dilated or Retinal Photos: _____ Do you wear glasses or contacts:_____

What is the main reason for your visit today?_____

Diabetic: Y/N Type: 1 or 2 Stable: Y/N Date of Diagnosis:_____

High Blood Pressure: Y/N Stable: Y/N Date of Diagnosis:_____

Allergies: Y/N Allergic to what?_____ Reaction:_____

Medication Allergy: Y/N Allergic to what?_____ Reaction:_____

Headaches: Y/N Describe briefly:_____ Eye Injuries: Y/N Type::_____

Current Medications:_____

Glaucoma: Y/N Cataracts: Y/N Dry Eye: Y/N Blurred Vision: Y/N Interested in contacts: Y/N

Do you work at a computer: Y/N How often:_____ How long:_____

**Family History:** Macular Degeneration: Y/N Relationship:_____

High Blood Pressure: Y/N Relationship:_____Diabetes: Y/N Relationship:_____

Glaucoma: Y/N Relationship:_____Cataracts: Y/N Relationship:_____

Patient Authorization Statement: I authorize the release of any medical information necessary to process this claim. I authorize payment of medical benefits to this provider for the services rendered. Payment for non-covered expenses is due at the time of service. Glasses and/or contacts left over 120 days will be considered abandoned property and will be disposed of or donated. No refund or credit will be given for glasses or contacts left over 120 days.

Signature:_____ Date:_____

E-Mail:_____ Who can we thank for referring you?_____

**Acknowledgement of Receipt of :**

1) **Notice of Privacy Practices and Record Release**
2) **Patient's Own Frame/ Lens Release Form**
3) **Patient Authorization Statement on Patient History Form**

Waters Family Eyecare/ Megan Waters, O.D. reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practice for Waters Family Eyecare, Patient's Own Frame/Lens release form and filled out the patient history form and signed the patient authorization statement. Signing this document means you have read the policy and practices, understand it and wish to proceed.

_____ _____

Signature of Patient Date

_____

Name of Patient (Print)

_____ _____

Signature of Representative or Guardian Relationship to Patient