WELCOME TO CUTLERVILLE EYECARE

Date:_____
Name:_____ **Date of Birth:**_____

Address:_____

_____

Account Financial Responsibility: Name:_____Date of Birth:_____

Address:_____

If under 18- both parents name :
_____

Home Phone:
Work/Day Phone:
Cell Phone:
Email:(please print)_____

How are you planning to pay for today's services:
____Cash ____Check ____ Visa MC Discover

Primary Care Physician: _____

Insurance:
____ Medical ____ Vision
Policy Holder: _____ Date of Birth _____
Contract # _____ Employer _____

Other Insurance:_____
____ Medical ____ Vision
Policy Holder: _____ Date of Birth _____
Contract # _____ Employer _____

Preferred Language: ____ English ____ Spanish

Race: ____ **Prefer not to answer**

____ Asian ____ African American ____Caucasian ____Hispanic ____Other

Ethnicity: ____ **Prefer not to answer**

___American ___African ___Dutch ___French Canadian ___German ___Irish ___Other

Communication Preference:

____ Cell Phone ____ Day Phone ____ Email ____Home Phone ____ Mail

Please list the name(s) of anyone to whom you would like information released to:

Name _____ Phone _____

Name _____Phone _____

I certify that I have received a copy of Cutlerville Eyecare's Notice of Privacy Practices

Signed:_____

This information is required by the Federal Healthcare Mandate, Thank you for your cooperation in completing this form

MEDICAL INFORMATION *Condition of General Health*_____

Do you have problems with any of these systems (Please circle)

Allergic/Immunologic	*Y/N*		*Gastrointestinal*	*Y/N*		*Immunologic*	*Y/N*		*Psychiatric*	*Y/N*
Cardiovascular	*Y/N*		*Genitourinary*	*Y/N*		*Integumentary (skin)*	*Y/N*		*Respiratory*	*Y/N*
Constitutional	*Y/N*		*Ears/Nose/Mouth/Throat*	*Y/N*		*Musculoskeletal*	*Y/N*			
Endocrine (glands)	*Y/N*		*Hematologic / Lymphatic*	*Y/N*		*Neurological*	*Y/N*			

Do you have:			***Do any of your relatives have:***		***Family Member(s) :***
Allergies	*Y/N*		*Cataracts*	*Y/N*	
Asthma	*Y/N*		*Crossed Eyes*	*Y/N*	
Diabetes	*Y/N*		*Diabetes*	*Y/N*	
Heart Problems	*Y/N*		*Glaucoma*	*Y/N*	
High Blood Pressure	*Y/N*		*High Blood Pressure*	*Y/N*	
Thyroid	*Y/N*		*Macular Degeneration*	*Y/N*	
Any other medical Problems:			*Other conditions:*		

Name of family Doctor:_____ Date of last visit:_____

Height _____ Weight _____ Prefer not to answer _____

Have you ever had a serious operation or injury? Yes / No Please explain:_____

_____

Do you use cigarettes/tobacco? Y / N How often_____ Alcohol? Y/N How often_____

Medication taken, if any _____

_____

Medication Allergies_____

Personal Eye Information:

Have you ever had any:		*Please explain, include date of occurrence:*		
Eye Diseases	*Y/N*		*Last Vision Exam:*	
Eye Injuries	*Y/N*			
Eye Surgery	*Y/N*		*Previous Eye Doctor:*	
Other Eye Problems	*Y/N*			

*Reviewed:*_____

Dr's Initials: _____

Note: Most insurance policies pay only a portion of your total charges. If you have any questions about your coverage, please contact your representative. We do not guarantee the accuracy of benefit information given to us by insurance companies!!! Please understand that financial responsibility for your account is yours, not the responsibility of your insurance company. I authorize the release of any medical or other information necessary to process insurance claims. I hereby authorize my insurance benefits to be paid directly to Cutlerville Eyecare. I am responsible for all balances 30 days after insurance is billed.

Patient signature: _____Date : _