EYECARE REGISTRATION AND HISTORY

Date _____

SS# _____

Patient Name _____
Last Name

_____ _____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

Email _____

Sex ☐ M ☐ F

Age ___ Birthdate _____

Spouses Name _____

Birthdate _____ SS# _____

Employer _____

Insurance Company _____

Member I.D. _____

Group # _____

Subscriber Name_____

Birthdate _____ SS# _____

Relationship to patient _____

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. James F Citek all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-names doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent or Guardian

_____
Printed Name

_____ _____
Date Relationship to Patient

Home (___) _____ Cell (___) _____ Best time to reach you _____
IN CASE OF EMERGENCY CONTACT
Name _____ Relationship _____

Home (___) _____ Cell (___) _____ Work Phone Cell (___) _____ ext _____

Eye Dr. Name _____

Date of last visit _____

Date of last exam _____

Do you wear glasses? ☐ Y ☐ N
☐ All the time ☐ Occasionally
☐ Reading ☐ Driving ☐ TV

Do you wear contacts? ☐ Y ☐ N
Type/Brand _____
Describe any problems you have with your contacts _____

_____

Place a check on "Yes" or "No" to indicate if you have or have had any of the following:

Bloodshot eyes	☐ Yes ☐ No	Floaters or Spots	☐ Yes ☐ No
Blurred Distance	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No
Blurred Near	☐ Yes ☐ No	Headaches	☐ Yes ☐ No
Burning Eyes	☐ Yes ☐ No	Itching Eyes	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	Light Sensitive	☐ Yes ☐ No
Color Vision Poor	☐ Yes ☐ No	Loss of Vision	☐ Yes ☐ No
Crossed Eyes	☐ Yes ☐ No	Migrane	☐ Yes ☐ No
Discharge	☐ Yes ☐ No	Night Vision Poor	☐ Yes ☐ No
Dizzy Spells	☐ Yes ☐ No	Seeing Halos	☐ Yes ☐ No
Double Vision	☐ Yes ☐ No	Seeing Flashes	☐ Yes ☐ No
Dry Eyes	☐ Yes ☐ No	Temp Vision Loss	☐ Yes ☐ No
Eye Infection	☐ Yes ☐ No	Twitching Eyelid	☐ Yes ☐ No
Eye Injury	☐ Yes ☐ No	Red Eyes	☐ Yes ☐ No
Eye Strain	☐ Yes ☐ No	Vision Poor	☐ Yes ☐ No
Faint/Blackout	☐ Yes ☐ No	Watering Eyes	☐ Yes ☐ No

Primary Physician's Name _____ Date of Last Visit _____

Place a check on "Yes" or "No" to indicate if you have or have had any of the following. Also place a mark to indicate if a blood relative has had any of the following problems.

	Yourself		Family Member			Yourself		Family Member	
AIDS/HIV	☐ Yes	☐ No	☐ Yes	☐ No	Hepatitis (Type ___)	☐ Yes	☐ No	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	☐ Yes	☐ No	Lazy Eye	☐ Yes	☐ No	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	☐ Yes	☐ No	Lupus	☐ Yes	☐ No	☐ Yes	☐ No
Bleeding	☐ Yes	☐ No	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	☐ Yes	☐ No
Blindness	☐ Yes	☐ No	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	☐ Yes	☐ No	Poor Color Vision	☐ Yes	☐ No	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	☐ Yes	☐ No	Retinal Disease	☐ Yes	☐ No	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	☐ Yes	☐ No	Shingles	☐ Yes	☐ No	☐ Yes	☐ No
Drug Sensitivity	☐ Yes	☐ No	☐ Yes	☐ No	Skin Conditions	☐ Yes	☐ No	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	☐ Yes	☐ No	Stroke	☐ Yes	☐ No	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	☐ Yes	☐ No	Thyroid Conditions	☐ Yes	☐ No	☐ Yes	☐ No
Eye Surgery	☐ Yes	☐ No	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	☐ Yes	☐ No	Turned Eye	☐ Yes	☐ No	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No	☐ Yes	☐ No	Heart Condition	☐ Yes	☐ No	☐ Yes	☐ No

Are you pregnant? ☐ Yes ☐ No
Number of Children _____

Tobacco Use? ☐ Yes ☐ No
Alcohol Use? ☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking, including eye drops:

_____
_____
_____
_____

Name/Location of Pharmacy_____

ALLERGIES

List your allergies to medications or other substances.

_____
_____
_____
_____
_____
_____

Medicare Authorization

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to James F. Citek O.D. for any services furnished to me by the above provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____ _____
Signature of Beneficiary, Guardian or Personal Representative Date

_____ _____
Please print name of Beneficiary, Guardian or Personal Representative Date