PATIENT INFORMATION

Name: ______________________________ Soc. Sec.# ____________
Last Name First Name Initial

Address: ______________________________ Home Phone: ____________

City: ____________ State: ______ Zip: ______ Cell Phone: ____________

Sex: M ☐ F ☐ Age: ______ Birthdate: ______ E-mail: ____________

Patient Employed by: ____________ Occupation: ____________

Business Address: ____________ Business Phone: ____________

Spouse's Name: ____________ Date of Birth: ____________

Family Physician: ____________ Phone: ____________

Whom may we thank for referring you? ____________ Your Optometrist: ____________

What is your reason for visit? ____________ Last exam date: ____________

In case of emergency list the nearest friend or relative not living with you. Relationship: ____________

Name: ____________ Address: ____________

City: ____________ State: ______ Zip: ______ Phone: ____________

INSURANCE INFORMATION

Person responsible for the bill: ______________________________
Last Name First Name Initial

Relationship to the patient: ____________ Birthdate: ______ Soc. Sec.# ____________

Address (if different from the patient's) ____________ Phone: ____________

City: ____________ State: ____________ Zip ____________

Person Responsible Employed by: ____________ Occupation: ____________

Business Address: ____________ Business Phone: ____________

Insurance Company: ______________________________

Contact # ____________ Group # ____________ Subscriber I.D. # ____________

AUTHORIZATIONS

I, the undersigned, have insurance coverage with ______________________________

And assign directly to **Dr. E. Lelis, M.D. & Associates** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid for by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

______________________________ ____________
Signature of Insured Guardian Date

INSURANCE AUTHORIZATION

I request that payment of authorized insurance benefits be made either to me or on my behalf to **Dr. E. Lelis, M.D. & Associates** for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorized release of medical information necessary to pay the claim. If " other health insurance" is indicated in item 9 of the HFCA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the insurance carrier.

______________________________ ____________
Signature of Insured Guardian Date

PLEASE FILL OUT ADDITIONAL INFORMATION ON REVERSE SIDE

What eye problems are you presently experiencing? ______________________________

____

CONDITIONS Check (√) conditions you have or have had in the past.

☐ Blurred Vision	☐ Eye Infection	☐ Headaches	☐ Seeing Halos
☐ Cataracts	☐ Eye Injury	☐ Hypertension	☐ Sensitivity to Light
☐ Crossed Eyes	☐ Eye Surgery	☐ Loss of Vision	☐ Wear Contact Lenses
☐ Diabetes	☐ Floaters	☐ Retinal disease	Type of Lenses ______
☐ Double Vision	☐ Glaucoma	☐ Seeing Flashes	Hours per Day ______

List any previous eye surgeries, injuries or problems? ______________________________

____

ROS: Do you have problems in the following areas?

Constitutional (Fever, Weight Loss)	Yes / No	______
Skin / Breast	Yes / No	______
Head (headaches, migraines)	Yes / No	______
Ear, Nose, Throat, Mouth, Neck	Yes / No	______
Lungs / Breathing (Asthma, Emphysema)	Yes / No	______
Heart / Blood Vessels (Heart Attack / High Blood Pressure)	Yes / No	______
Stomach / Intestines (Ulcers / Gastritis)	Yes / No	______
Genitals / Kidney / Bladder	Yes / No	______
Bones, Joints, Muscles (Arthritis)	Yes / No	______
Neurological (Stroke, Alzheimer's)	Yes / No	______
Lymph Nodes / Swelling	Yes / No	______
Psychiatric	Yes / No	______
Endocrine (Diabetes, Thyroid)	Yes / No	______

PAST MEDICAL HISTORY

Current Medications: ______________________________

____

____

What medications are you allergic to? ______________________________

____

SOCIAL HISTORY

Occupation: ______________________________

Do you smoke? Yes / No

Any health problems in the family? If "yes", indicate relationship to the patient.

Strabismus (Crossed or Turning Eyes)	Yes / No	______
Corneal Disease	Yes / No	______
Cataract	Yes / No	______
Glaucoma	Yes / No	______
Macular Degeneration	Yes / No	______
Diabetes	Yes / No	______
Heart Attacks	Yes / No	______
High Blood Pressure	Yes / No	______
Thyroid Disease	Yes / No	______
Heart Disease	Yes / No	______

For in-office use only below line:

History reviewed (Date and Initials): ______ ______ ______ ______

______ ______ ______ ______