

PATIENT INFORMATION

Name: _____ Soc. Sec.# _____

Last Name

First Name

Initial

Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Sex: M F Age: _____ Birthdate: _____ Drivers License # _____

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.

<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Eye Infection	<input type="checkbox"/> Headaches	<input type="checkbox"/> Seeing Halos
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Eye Injury	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Sensitivity to Light
<input type="checkbox"/> Crossed Eyes	<input type="checkbox"/> Eye Surgery	<input type="checkbox"/> Loss of Vision	<input type="checkbox"/> Wear Contact Lenses
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Floaters	<input type="checkbox"/> Retinal disease	Type of Lenses _____
<input type="checkbox"/> Double Vision	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> 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): _____