BROOKWOOD EYECARE

Date: ___/___/_____

FULL NAME_____

DATE OF BIRTH_____

PATIENT MEDICAL HISTORY

Name of physician_____
City_____
Last date of check up_____

CURRENT MEDICATIONS

(List the names of medications including eye drops, vitamins, and birth control pills)

_____

_____

Any allergies to medication? YES NO
If so, what medications?

_____

_____

Have you had any surgeries? YES NO
Do you use cigarettes/tobacco, alcohol, or other substances? YES NO

Have you ever been diagnosed or treated for any of the following health problems?

Allergies	**YES NO**
Arthritis	**YES NO**
Blood/Lymph	**YES NO**
Bronchitis	**YES NO**
Cancer	**YES NO**
Cholesterol	**YES NO**
Diabetes	**YES NO**
Digestive/Ears/Nose/Throat	**YES NO**
Endocrine	**YES NO**
Eczema/Rashes	**YES NO**
Genitourinary	**YES NO**
High Blood Pressure	**YES NO**
Integumentary (Skin)	**YES NO**
Kidney	**YES NO**
Muscle/Bone	**YES NO**
Neurological	**YES NO**
Psychological	**YES NO**
Respiratory/ COPD/ Asthma Etc.	**YES NO**
Sinus	**YES NO**
Throat Infections	**YES NO**
Thyroid	**YES NO**
Unusual Wight Losses/Gains	**YES NO**
Currently Pregnant?	**YES NO**

PATIENT EYE HISTORY

Date of last eye exam_____
Do you currently wear glasses? YES NO
Do you currently wear contacts? YES NO
What kind?_____
Solution used?_____
Are you satisfied with the vision, and comfort of your contact lenses? YES NO
Would you prefer clear, or colored contacts?
☐ **Clear** ☐ **Colored** ☐ **Both**
Do you use the computer? YES NO ___#hours

Occupation:_____
List any hobbies you may have in which clear vision is important
_____

_____

Have you ever experienced been diagnosed or treated for any of the following?

[ ] Blurry Vision [ ] Burning [ ] Itchiness
[ ] Grittiness [ ] Corneal abrasion
[ ] Crossed Eye/Eye Turn [ ] Lazy Eye
[ ] Double Vision [ ] Eye Infections
[ ] Eye injury [ ] Flashes of Light
[ ] Floaters/Spots [ ] Cataracts
[ ] Glaucoma [ ] Headaches
[ ] Sunlight Sensitivity [ ] Iritis/Uveitis
[ ] Macular Degeneration [ ] Dry Eyes
[ ] Retinal Detachment [ ] Tearing
[ ] Trouble seeing at night?
[ ] Other eye disorder(s)_____

FAMILY EYE/MEDICAL HISTORY

Is there a family medical history of any of the following list (Please circle, and list relationship)

Blindness	**Yes No**	**Who:**	_____
Cataracts	**Yes No**	**Who:**	_____
Corneal Problems	**Yes No**	**Who:**	_____
Diabetes	**Yes No**	**Who:**	_____
Glaucoma	**Yes No**	**Who:**	_____
Heart Disease	**Yes No**	**Who:**	_____
Lazy Eye	**Yes No**	**Who:**	_____
Retinal Problems	**Yes No**	**Who:**	_____

Sign:_____

Brookwood Eyecare

Welcome To Our Office: Gender: (Please circle one): M F Date: _____

Patient Last Name:_____Patient First Name:_____Pat. DOB_____

Insurance Subscribers Last Name:_____First Name:_____DOB_____

Address:_____

City_____State_____Zip Code_____

Home Phone:_____Work:_____Cell:_____

E-mail:_____

Insurance Subscribers Member ID# or Last four of SSN:_____

Payment Method: Self Pay:_____Insurance:_____

Vision Insurance:_____Primary Medical Insurance:_____

Insurance Authorization:
I authorize and request my insurance company to pay to the eye doctor benefits otherwise payable to me.
I understand that my insurance carrier may pay less than the actual bill for service. I agree to be responsible for the payment of all services rendered on my behalf or my dependants.

Signature:_____ Date:_____

HIPAA PRIVACY ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE:

I, _____(Please print name of patient or legal representative) have been presented with the Notice of Privacy Policy of Dr. Birdsong & Associates (the Provider), and have been offered a copy of such policy to keep for records.

Please check one:
_____ I hereby acknowledge receipt of the policy.
_____ I hereby REFUSE to acknowledge receipt of the policy. I understand that even though I refuse to sign this ACKNOWLEDGEMENT, the Provider may still provide treatment to me.

Signature:_____ Date:_____