PT #: ______________
For office use only

SWISS EYECARE

WELCOME TO OUR OFFICE

Today's Date: ______________________________

Name: ______________________________________
Last First Mi

Date of birth (mm/dd/yy): _____________________

Age: __________ Sex: ☐ M ☐ F

Address:

Street: ______________________________________

City: ____________ State: _____ Zip: ___________

Home Phone: _______________________________

Cell Phone: ________________________________

E-Mail: ___________________________________

May we correspond with you by e-mail? ☐ Yes ☐ No

Employer/School: ___________________________

Occupation/Grade: __________________________

How did you hear about our office?

☐ Insurance ☐ Friend ☐ Newspaper ☐ Internet

☐Other: ___________________________________

Social Security: ______________________________
Per insurance requirement only

Date of last exam: ___________________________

What is the major purpose of this visit?

____

____

Emergency Contact

Name: _____________________________________

Phone: _____________________________________

Relationship: ________________________________

Insurance

Health: ____________________________________

Vision: ____________________________________

Policyholder's Name: _________________________

Policyholder's DOB: __________________________

Policyholder's SS#: ___________________________

Relationship with Policyholder: ________________

Current Medications (RX or over the counter)			**NAME OF MEDICATION**
Antihistamines	☐ Yes	☐ No	______________________
Blood Pressure Pills	☐ Yes	☐ No	______________________
Diabetes	☐ Yes	☐ No	______________________
Eye Drops	☐ Yes	☐ No	______________________
Oral Contraceptives	☐ Yes	☐ No	______________________
Sleeping Tablets	☐ Yes	☐ No	______________________
Other: ______________			______________________

Family Medical History			**RELATIONSHIP**
Blindness	☐ Yes	☐ No	______________________
Cataracts	☐ Yes	☐ No	______________________
Glaucoma	☐ Yes	☐ No	______________________
Diabetes	☐ Yes	☐ No	______________________
Heart Disease	☐ Yes	☐ No	______________________
Macular Degeneration	☐ Yes	☐ No	______________________
Other: ______________			______________________

Do you have any allergies, medication, or other? If yes, please explain: ______________________

____

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

☐ Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive? ☐ Yes ☐ No IF YES, do you have visual difficulty when driving? ☐ Yes ☐ No
IF YES, please describe: ______________________________

Do you use tobacco products? ☐ Yes ☐ No IF YES, what type: ________ Amount: ______ How long: ______
Do you drink alcohol? ☐ Yes ☐ No IF YES, what type: ________ Amount: ______ How long: ______
Do you use illegal drugs? ☐ Yes ☐ No IF YES, what type: ________ Amount: ______ How long: ______
Are you pregnant? ☐ Yes ☐ No IF YES, what type: ________ Amount: ______ How long: ______
Are you currently breastfeeding? ☐ Yes ☐ No
Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Review of Systems

Do you currently, or have you ever had any problems in the following areas? Please check all that apply.

	Yes	No	?
Constitutional			
Fever, Weight Loss/Gain	☐	☐	☐
Neurological			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
Eyes			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision/Halos	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess Tearing/Watering	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infection of Eye/Lids	☐	☐	☐
Sties or Chalazion	☐	☐	☐
Tired Eyes	☐	☐	☐
Endocrine			
Thyroid/Other Glands	☐	☐	☐

	Yes	No	?
Ears, Nose, Mouth, Throat			
Allergies, Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
Respiratory			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Vascular/Cardiovascular			
Diabetes	☐	☐	☐
Heart Pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
Gastrointestinal			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
Bones/Joints/Muscles			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
Lymphatic/Hematologic			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐

If you answered YES to any of the above or have a condition not listed, please explain and list the medications:

____

____

I do hereby authorize release of any medical information necessary to process insurance claims, and accept personal responsibility for the payment of charge for services rendered.

I have read and understand the above.

______________________________ ______________ ______________
Signature of Responsible Party *Relationship* *Date*

Advance Beneficiary Notice (ABN)

- Vision insurance DOES NOT pay for all care, even those tests or procedures your Eyecare Provider may recommend based on his or her professional expertise.
- Swiss Eyecare will bill your medical insurance.

What you need to do now:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions you may have after you finish reading.

Patient Information:

Patient Name: ___________________________________

Patient Date of Birth: _____________________________

Date of Service: _________________________________

Recommended Services	Description of Service
Anterior Segment Photos	To capture images on the front surface of the eye in or to diagnose and treat those diseases.
Fundus Photography	To capture images on the back of the eye in order to detect early retinal diseases such as Glaucoma and Macular Degeneration.
Specular Microscopy	To measure the endothelial layer of the cornea to ensure proper corneal health for patients that wear contact lenses and diagnose certain corneal diseases such as Gurtata and Funch's.
Visual Field	To check Blindspots to help diagnose early Glaucoma and other retinal diseases.

____   __________________________

Signature of Responsible Party   *Date*

____

Relationship to Patient

Swiss Eye Care

2625 Old Denton Rd STE# 548
Carrollton, TX 75007

PATIENT AUTHORIZATION

I authorize any holder of medical records including Psychiatric, Alcohol, Drug Abuse and HIV/AIDS or other information about me to be released to the SSA or Health Care Financial Administrator or it's intermediaries or carrier, or any other insurance carrier, any information needed for this or a related claim. I permit a copy of the authorization to be used in place of the original, and request payment of the medical insurance benefit either to myself or to the medical party who accepts assignment.

I agree to be responsible for payment of service render.

____ ________________________
Signature of Responsible Party *Date*

____
Relationship to Patient

***If you have any insurance, we will be glad to help you file for any benefits to which you are entitled. However, it remains the responsibility of the individual patient to settle his/her account promptly.**

Acknowledgement of Receipt for HIPAA Compliancy

I acknowledge that I've received or read a copy of Swiss Eye Care's notice of Privacy Practices.

____ ________________________
Signature of Responsible Party *Date*

____
Relationship to Patient