PATIENT HEALTH HISTORY

Please review, make necessary changes and supply any missing information.

Patient Name				Birthdate	/ /
Last Eye Doctor		Reason for Last Visit		Date of last eye exam	
Primary Care Physician				Date of last visit	

CONTACT LENS HISTORY					
Brand of current contact lenses?			How often to you replace your contacts?		
Normal wearing hours?		Overnight? Y/N		Everyday Wear? Y/N	Occasional? Y/N

Current Glasses Information

Age of current glasses?	1 yr	2 yr+	Age of sunglasses?	1 yr	2 yr+
Do you use glasses for	Computer	Sports/Fishing/Hunting	Reading	Near work/Hobbies	

DRUG ALLERGIES			
Allergy	Onset Date	Reaction	Severity

MEDICATIONS			
Please cross out any medications that you are no longer taking Please list all prescriptions, over the counter and herbal medications			
Date	Name	Strength	Directions

MEDICAL ALERTS
Please list all medical alerts (i.e., Do Not Dilate, epilepsy, DNR / DNI)

Do you take medications for any of these conditions?

	Y	N		Y	N		Y	N
Diabetes			Heart Disease			Glaucoma		
High Blood Pressure			High Cholesterol			Retinal Disease		
Kidney Disease			Endocrine / Hormonal			Macular Degeneration		
Allergic / Immunologic			Lupus/Arthritis			Thyroid		

Do you or any close family member have any medical history of:

Diabetes	Glaucoma	High Cholesterol	Retinal Disease
Cataracts	Other Disease	Kidney Disease	Cancer
Macular Degeneration	Blindness	Dry Eye	Heart Disease
Eye Injury	Strabismus	Amblyopia	Hypertension

SOCIAL HISTORY	
What type of recreational drugs do you use?	
What type of alcohol do you drink, how much and how often?	
Are you a smoker, former smoker or never smoked? Do you smoke everyday or some days?	
What type of tobacco do you use, how much, how often and for how long?	
Occupation	
Work status / duties	
Hobbies	

EYE SURGICAL INFORMATION				
Date	**Eye**	**Procedure**	**Surgeon**	**Complications**

Southern Eye Care Financial Policy

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Professional fees are due when services are rendered. A deposit of 50% is required towards the total cost of glasses or contacts before an order can be placed. The balance is due in full at the time of dispensing. We accept personal checks, cash, Discover, Visa MasterCard and CareCredit.

2. When glasses or contacts are purchased through VSP or any other insurance, the balance is due in full when the order is placed.

3. **Keep in mind that your insurance policy is basically a contract between you and your insurance company**. As a service to you, we will file your insurance claim if you assign the benefits to the doctor.

4. **If your insurance company does not pay the practice within 45 days, you are responsible for all fees due.**

5. If you are insured by a plan that we do not accept, we will prepare and send the claim for you on an unassigned basis. **Therefore, our charges for your care are due at the time of service.**

6. Not all-insurance plans cover all services. In the event your insurance plan determines a service to be “not covered,” you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

I have read and understand the practice’s financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

X____/_____/_______

Signature of patient (or responsible party, if minor) Date

Payments can be made through CareCredit at no interest for 6 months.
www.carecredit.com or call 1-800-365-8295 to apply.