Patient Information: Date: _____

Last Name: _____ First Name: _____ MI: ___

Prefix:_____ Suffix_____ Male . Female .

Date of Birth: _____ Social Security# _____

Home Address:_____Apt#_____

_____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cellular Phone:_____

E-Mail: _____

Marital Status: . Single . Married . Divorced/Widowed

Employer & Occupation: _____ Work #:_____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____

Insurance Plan: _____ ID#:_____ Group#: _____

Who may we thank for referring you to us?

_____

Primary Physician? _____ Phone:_____

Optometrist?_____Phone:_____

SOLL EYE

Financial Assignment and Agreements

I acknowledge that for the purpose of evaluation, my pupils may be dilated. This may result in blurred vision, possibly making driving difficult. Please ask for assistance if your vision is significantly affected.

I request that payment of authorized Medicare and /or insurance benefits be made on my behalf to Soll Eye for any services furnished to me by them. I authorize any holder of medical information about me to release to the Health Care Financing Administration, it's agents, or any other insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing.

I understand that I am financially responsible for all charges not covered by insurance. This includes any deductibles or co pays.

Soll Eye participates in many insurance plans. We do our best to learn as many of their requirements as possible.

However, it's not always possible. Please make sure that you understand your insurance and their requirements.

Medical insurances (ie. Medicare) do not pay for the examination required for glasses (refraction). I agree to be personally and fully responsible for payment.

I authorize Soll Eye to communicate with me by phone, answering machine, written correspondence or E-mail at home or business regarding appointments, care or billing.

I agree to the release of my medical information to my personal physician(s) or optometrist (s).

I give permission to discuss my medical information with the specific individuals named below: (ie. Spouse, adult children, care giver, emergency contact)

1._____
2._____

I acknowledge that a copy of Soll Eye privacy policy has been provided to me for review and that a copy is available upon my request.

I understand the above and agree to abide by the regulations of my insurance company and the policy of Soll Eye.

Signature: _____ (Patient or Legal Guardian)

Date: _____

Witness: _____ Date

SOLL EYE

Medical History Form

NAME:_____ DOB: _____ DATE: _____

Chart#: _____ Date of Prior HX Form: _____

OCULAR HISTORY:
Have YOU ever been diagnosed with any of the following eye problems:
.. Y .. N Glaucoma

.. Y .. N Macular Degeneration

.. Y .. N Dry Eyes

.. Y .. N Retinal Detachment

.. Y .. N Cataracts

.. Y .. N Diabetic Retinopathy

.. Y .. N Lazy Eye

EYE DROPS OR EYE MEDICATIONS:

EYE SURGERIES/LASERS: (PLEASE LIST TYPE OF SURGERY AND DATE)

PATIENT MEDICAL HISTORY:

Do YOU have any of the following medical problems (please check yes or no):

.. Y .. N High Blood Pressure .. Y .. N Arthritis

.. Y .. N Diabetes .. Y .. N Migraines

.. Y .. N Heart Disease .. Y .. N Depression

.. Y .. N Cancer .. Y .. N Shingles

.. Y .. N Asthma/Emphysema .. Y .. N Thyroid

.. Y .. N Stomach Disorders .. Y .. N Sinus Infections

.. Y .. N Kidney Disease .. Y .. N Hard of Hearing

.. Y .. N Neurologic/Strokes .. Y .. N Cholesterol

.. Y .. N Blood Disorders .. Y .. N Skin Disorders

.. Y .. N Frequent Fatigue .. Y .. N Weight loss/gain

.. Y .. N Sleep Apnea .. Y .. N Pacemaker/Defibulator

ALLERGIES: Seasonal? .. Y .. N _____

Latex/Environmental? .. Y .. N _____

Drug/Other? .. Y .. N _____

SYSTEMIC MEDICATIONS:

SOCIAL HISTORY:

Do you drive? .. Yes .. No Comment: _____

Do you smoke? .. Yes .. No Packs per day: _____

Do you drink alcohol? .. Yes .. No Amount: _____

Do you presently exercise: .. Yes .. No Comment: _____

FAMILY HISTORY: (Do any of your Blood Relatives have the following? If yes, state relationship)

.. Y .. N Diabetes _____

.. Y .. N Glaucoma _____

.. Y .. N Macular Degeneration _____

.. Y .. N Amblyopia (Lazy Eye) _____

.. Y .. N Retinal Detachment _____

.. Y .. N High Blood Pressure _____

.. Y .. N Heart Disease _____

.. Y .. N Strokes/Neurological Disease _____

.. Y .. N Cancer _____

Technician: _____

Doctor: _____