Dailey Harvey Eye Associates

Welcome to our office. Please complete this form, which will become a part of your medical file.

Any service not covered by your insurance carrier (i.e., refractions, co-payments, contact lens fitting fees) must be paid at the time services are rendered.

ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, private insurance, and other health plan for services rendered by Dailey Harvey Eye Associates. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that in the event my account balance becomes past due, I will be responsible for collection fees (40 percent) plus the outstanding balance, along with reasonable attorney fees and court costs incurred by Dailey Harvey Eye Associates.

Signed: ______________________________ Date: ________________

EMERGENCY CONTACT PERSON:

Name: ______________________________ Telephone: ______________________________

I. PATIENT INFORMATION:

Today's Date: __________ Date of Birth ______

Last Name: ______________ First: ____________ M.I. ____ Sex: _____ Age: _____

Address: ____
Street *City* *State* *Zip*

Telephone: (Home)______________ (Office)______________ (Cell)______________

Social Security #: ____________ Marital Status: ____ Spouse's Name: _______ Spouse's Date of Birth: _____

Medical Doctor *(name)*: ______________________________

Referring Doctor *(if you were referred to our office by a doctor or optometrist)*: ______________________________

II. INSURANCE - POLICY HOLDER INFORMATION

Name: ______________________________ Telephone Number ______________________________
Policy Holder Policy Holder

Address: ____
Policy Holder *Street* *City* *State* *Zip*

Date of Birth:______________________________ Social Security Number:______________________
Policy Holder Policy Holder

III: FAMILY HISTORY *(Has anyone in your family had any of the following?)*:

			Relationship
Glaucoma	❏ Yes	❏ No	________
Cataract	❏ Yes	❏ No	________
Macular degeneration	❏ Yes	❏ No	________
Other Eye Condition	❏ Yes	❏ No	________
If yes, please explain: ________________			
Diabetes	❏ Yes	❏ No	________

IV: SOCIAL HISTORY:

Employer: ____________________

Occupation: ____________________

- Do you wear eyeglasses? ❏ Contact Lenses? ❏
- Do you smoke? ❏ Yes ❏ No
- Do you consume alcohol? ❏ Yes ❏ No
- Do you drive a motor vehicle? ❏ Yes ❏ No

V. MEDICAL/SURGICAL HISTORY: (please list the following):

1. Eye Operations/Other Operations ❑ None

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2. Eye Diseases (glaucoma, cataract) ❑ None

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3. Medical Diseases (arthritis, diabetes) ❑ None

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4. Current Medications ❑ None

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5. Drug Allergies ❑ None

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6. Eye Medications ❑ None

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VI: REVIEW OF SYSTEMS *(Do you currently have any of the following problems?):*

	Yes	No	*(If yes, please explain)*
Chronic fever, unexpected weight loss/gain, fatigue	❑	❑	______________________
Ear/nose/throat problems (e.g., hearing loss, sinus problems)	❑	❑	______________________
Heart problems (e.g., chest pain, irregular heartbeat)	❑	❑	______________________
Respiratory problems (e.g., shortness of breath, wheezing, asthma, bronchitis)	❑	❑	______________________
Gastrointestinal problems (e.g., bowel changes, abdominal pain, diarrhea)	❑	❑	______________________
Urinary problems (e.g., pain or discomfort, bladder infections)	❑	❑	______________________
Skin disease (e.g., rashes, eczema, dermatitis)	❑	❑	______________________
Musculoskeletal problems (e.g., muscle aches, arthritis, swollen joints)	❑	❑	______________________
Neurologic problems (e.g., numbness, weakness, paralysis, headache)	❑	❑	______________________
Psychiatric problems (e.g., depression, anxiety)	❑	❑	______________________
Allergic (e.g., seasonal allergies, hay fever)	❑	❑	______________________
Blurred vision	❑	❑	______________________
Double vision	❑	❑	______________________
Mucous discharge	❑	❑	______________________
Redness	❑	❑	______________________
Itching/burning	❑	❑	______________________
Excess tearing/watering	❑	❑	______________________
Glare/light sensitivity	❑	❑	______________________
Eye pain or soreness	❑	❑	______________________
Infection of eye or lid (blepharitis, stye)	❑	❑	______________________

Your medical doctor should be made aware of any of the above symptoms you are experiencing.

Physician Signature: ______________________________ **Date**______________

(Reviewed/Updated by Physician)