# LASER EYE CENTER
OF CAROLINA

Ophthalmic services provided by ***Eye Specialists of Carolina, PA***

## PATIENT INFORMATION

Name_____ Address_____
LAST FIRST MI

City/State/Zip_____ Birthdate_____/_____/_____ ❑ Male ❑ Female

Home Phone_____ Work Phone_____

SS#_____-_____-_____ Email _____

Are you: ❑ Minor ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Single

Your employer_____ Occupation_____

Business Address_____ City/State/Zip_____

Reason for today's visit?_____ Referred By?_____

Contact/Guardian_____ Relationship_____ Phone_____

## INSURANCE INFORMATION (*please provide us a copy of your cards*)

Insurance Company_____ ID#_____

**ANY SECONDARY INSURANCE?**

Insurance Company_____ ID#_____

## AUTHORIZATION

I authorize Eye Specialists of Carolina, PA to release any medical information necessary to process an insurance claim for payment on my behalf. Furthermore, if I am not eligible for insurance, I understand that I am personally responsible for full payment to Eye Specialists of Carolina, PA for all medical services rendered.

Signature (patient or parent)_____Date_____

# MEDICAL AND EYE HISTORY

Last Eye Exam?_____ By Whom?_____

Medical/Primary Physician_____

Other Physicians you see regularly?_____

ALLERGIES (to medications, latex, x-ray dyes, etc)

❑ None

_____

_____

_____

_____

CURRENT MEDICATIONS

❑ None

_____

_____

_____

_____

_____

_____

_____

_____

PAST SURGERIES

❑ None

_____

_____

_____

_____

Present/Previous Eye Problems

| | *Patient* | *Family* |
|---|---|---|
| Cataract | ❑ | ❑ |
| Glaucoma | ❑ | ❑ |
| Lazy Eye | ❑ | ❑ |
| Strabismus | ❑ | ❑ |
| Retinal Problems | ❑ | ❑ |
| Macular Degeneration | ❑ | ❑ |
| Iritis | ❑ | ❑ |

Present/Previous Medical Problems

| | *Patient* | *Family* |
|---|---|---|
| Stroke | ❑ | ❑ |
| Diabetes | ❑ | ❑ |
| Heart Problems | ❑ | ❑ |
| Arthritis | ❑ | ❑ |
| Breathing Problems | ❑ | ❑ |
| High Blood Pressure | ❑ | ❑ |
| Cancer | ❑ | ❑ |
| Hepatitis | ❑ | ❑ |
| Seizures | ❑ | ❑ |
| Kidney Disease | ❑ | ❑ |
| Bleeding Problems | ❑ | ❑ |
| Depression/Mental Illness | ❑ | ❑ |
| HIV/AIDs | ❑ | ❑ |
| Phlebitis/Blood Clots | ❑ | ❑ |
| Stomach Problems | ❑ | ❑ |
| Thyroid Problems | ❑ | ❑ |

Other Health Problems_____

Do you smoke? Yes ❑ No ❑ How much/often?_____

Do you drink alcohol? Yes ❑ No ❑ How much/often?_____

*Office use:*

REVIEW DATES _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____