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 _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____