

LASER EYE CENTER

O F C A R O L I N A



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

	<i>Patient</i>	<i>Family</i>
Cataract	☐	☐
Glaucoma	☐	☐
Lazy Eye	☐	☐
Strabismus	☐	☐
Retinal Problems	☐	☐
Macular Degeneration	☐	☐
Iritis	☐	☐

Present/Previous Medical Problems

	<i>Patient</i>	<i>Family</i>
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

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____