swiftcreek eye center

Swift Creek Eye Center, P.C., Optometrists

WELCOME

Thank you for choosing our office for your eyecare needs

PERSONAL INFORMATION

DATE _____

LAST NAME: _____ BIRTHDATE : ____/____/____ AGE: _____
(MM / DD / YY)

FIRST NAME: _____ TITLE CODE: MISS MRS. MR. MS. DR.

STREET: _____ MARITAL STATUS: SINGLE / MARRIED / OTHER

CITY: _____ EMPLOYMENT STATUS: Full Time/Part Time/Retired
Homemaker/Student

STATE: _____ ZIP: _____

HOME TELEPHONE : _____ FAMILY PHYSICIAN: _____

WORK TELEPHONE: _____ HOW DID YOU FIRST HEAR ABOUT OUR OFFICE? _____

EMPLOYER: _____

OCCUPATION: _____ WHAT NAME DO YOU PREFER TO BE CALLED?

SEX: M or F

SOCIAL SECURITY #: _____ METHOD OF PAYMENT: CASH / CHECK / CHARGE
(Circle One)

EMAIL ADDRESS: _____

CELL PHONE: _____

PERSON RESPONSIBLE FOR ACCOUNT

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ CITY: _____ ZIP: _____

HOME PHONE: _____ BUSINESS PHONE: _____

EMPLOYER: _____ OCCUPATION: _____

SOCIAL SECURITY NUMBER: _____

FINANCIAL POLICY

- Payment is due when services are rendered and before materials are ordered. Any exceptions must be approved in advance and finance charges (18%) will apply.
- Default of payment will subject account to all collection fees including court cost and attorney fees if applicable.
- We are glad to assist you in filling out your insurance forms, however, you are responsible for all professional charges at the time of service.
- Returned checks are processed through Check Collect. A $25 service charge will be applied by Check Collect.

INSURANCE INFORMATION

Name of Vision Insurance: _____

Primary Insured: _____

Primary Insured's Employer: _____

Primary Insured's Social Security Number: _____

Primary Insured's Date of Birth: _____

INSURANCE AUTHORIZATION

"I hereby authorize the Swift Creek Eye Center to furnish information to insurance carriers concerning my treatment."

_____ _____

Patient or Representative Signature and Date **Please Print Patient or Representative Name**

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

"I hereby acknowedge that I have received a copy of this practice's **NOTICE OF PRIVACY PRACTICES**. I understand that if I have any questions or complaints regarding my privacy rights that I may contact the person listed on the **Notice**. I further understand that the practice will offer me updates to this **NOTICE OF PRIVACY PRACTICES** should it be amended, modified or changed in any way."

_____ _____

Patient or Representative Signature and Date **Please Print Patient or Representative Name**

MEDICAL HISTORY QUESTIONNAIRE

Date: _____ **Name:** _____ **Birthdate:** _____ **Family Physician:** _____

Do you *currently* have any problems in the following areas? If "YES", provide information:

System	YES	NO	Explanation of problem
GENERAL/CONSTITUTIONAL (Fever, weight loss, other)			
EARS, NOSE, THROAT (Sinus, ear infection, chronic cough, dry mouth, etc.)			
CARDIOVASCULAR (Heart, hypertension)			
RESPIRATORY (Asthma, emphysema, etc.)			
GASTROINTESTINAL (Stomach ulcers, intestinal disease, etc.)			
ENDOCRINE (Diabetes, hypothyroid, etc.)			
SKELETAL (Osteoporosis, arthritis)			
SKIN (Acne, warts, skin cancer, etc.)			
NEUROLOGICAL/PSYCHIATRIC (Anxiety, depression)			
BLOOD (Cholesterol, anemia, lupus, etc.)			

Are you currently experiencing: flashes of light _____ floaters _____

PAST EYE HISTORY AND RELATED SYSTEMIC CONDITIONS

Have you EVER been diagnosed with the following conditions? If "YES" indicate when diagnosed and treated.

Condition	YES	NO	Date diagnosed and description of treatment
AGE RELATED MACULAR DEGENERATION			
GLAUCOMA			
CATARACTS			
EYE INJURY			
EYE SURGERIES			
DIABETES			
HIGH BLOOD PRESSURE			
CANCER			
STROKE			
ARTHRITIS			

Medications: (List all medications & vitamins you take regularly and the medical reason)

_____

_____

_____

_____

Allergies: (List any allergies to medications, foods or other allergens)

_____

_____

FAMILY HISTORY

M=mother F=father S=sister B=brother A=aunt U=uncle MGM=maternal grandmother

Condition	YES	NO	Relationship to Patient
BLINDNESS			
MACULAR DEGENERATION			
GLAUCOMA			
CATARACTS			
DIABETES			
CANCER			
OTHER			
UNKNOWN			

Reviewed **Patients Initials**

__/__/__ _____

__/__/__ _____

__/__/__ _____

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No

If yes - How many packs per day? _____

If no - Are you a former smoker? ☐ Yes ☐ No

Alcohol use: ☐ None ☐ Social only
☐ 1-2 drinks a day ☐ Above average use

Do you wear? ☐ Glasses ☐ Contacts

What color are your eyes? _____

Current Occupation: _____

_____ _____

Patient's Signature Date

Revised 2/01/2013