

**Welcome!**

**Please print and complete all parts**

Patient Name:(  Mr.,  Mrs.,  Miss,  Ms.)

Address:

Home Phone:

Work Phone:

City:

St:

Zip:

Occupation:

Date of Birth:

Sex:  Male  Female

Employer:

Marital Status:  S  M  D  W

Social Security #:

Spouse's Name:

Spouse's Employer:

Spouse's Work Phone:

**IF UNDER 18 YEARS OF AGE - Guardian Information**

Name:

Address:

City:

St:

Zip:

Home Phone:

Work Phone:

Primary Care Physician:

Phone:

Referred By:

**Insurance Information - Please complete all and present your insurance card(s).**

Primary Insurance:

Secondary Insurance:

Primary Insured Person:

Primary Insured Person:

Date of Birth:

Date of Birth:

Social Sec #:

Social Sec #:

Employer:

Employer:

I.D./Policy #:

I.D./Policy #:

Group #:

Group #:

**Payment Policy: Payment required at time of service unless prior arrangements have been made in advance. Understand there will be a \$7.00 monthly billing charge on accounts over 60 days past due.**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

**In order for us to file your insurance, we need your signature on both lines below.**

PATIENTS OR AUTHORIZED PERSON'S SIGNATURE. I authorize any medical information necessary to process this claim. I also request payment of benefits either to myself or to Denver Eye Clinic, who accepts assignment.

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the Denver Eye Clinic for services.

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Date

Patient Name:  D.O.B:  Date:

**Past Medical History**

Do you have or have you been treated for:

- Diabetes
- High Blood Pressure
- Heart Disease (Heart Attack, Irreg. Beat)
- Lung Disease (Asthma, COPD)
- Gastrointestinal Disease
- Neurological Disease
- Vascular Disease
- Arthritis
- Cancer
- Bleeding Disorder
- AIDS
- Other (If yes, please explain illness, duration of treatment, hospitalization, surgery/date):

**Medications**

Please list name, including over the counter

**Medical Allergies:**

**Past Surgical History**

Please list all past surgeries and/or injuries:

**Eye Disease/Surgery**

Do you have or have been treated for:

- Retinopathy (Diabetes, High Blood Pressure)
- Macular Degeneration
- Macular Edema
- Macular Hole
- Retinal Vein Occlusion
- Vitreous Floaters
- Retinal Tear
- Retinal Detachment
- Cataract
- Glaucoma
- Infection
- Inflammation
- Strabismus: Amblyopia
- Dry Eyes
- Corneal Disease

**Ocular Medications**

Please list name, including over the counter

**Review of Systems**

Any of the following problems (please check):

- Chronic fever,  unexpected weight loss/gain,  fatigue,
  - ear/nose/throat,  heart,  respiratory,  gastrointestinal,
  - urinary,  skin,  musculoskeleton,  neurologic,  psychiatric
- problems. Please explain if you have not already done so:

Other (Please explain duration, treatment, surgery):

**Family & Social History**

Do any medical or eye diseases run in your family? (Please explain if yes)

Do you smoke?  Y  N      How often?       Do you drink alcohol?  Y  N      How often?   
Do you use illicit drugs?  Y  N      How often?

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Physician Signature