Patient Name: (First, Last) _____

Gender: Female ☐ Male ☐ Other ☐

Address: _____

Apt: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Social Security: _____

Single: ☐ Married: ☐ Other: ☐

Cell Phone: _____

Alternate Phone: _____

Email Address: _____

Primary Care/Pediatrician/Subspecialty Information:

Name: _____ Phone: _____

Address: _____

City/Zip Code: _____

Please briefly explain the reason for your visit:

_____

_____

Last Eye Exam: _____

Eye drops: Please list all over the counter and prescription eye drops you use.

_____

_____

Visual History:

Do you wear *eye glasses*?	Y	N
Do you wear *contacts*?	Y	N
Do you have *dry eyes*?	Y	N
Do you experience; *itchy/burning/tearing*?	Y	N
Have you ever been diagnosed with *glaucoma*?	Y	N
Have you ever had *Lasik Eye Surgery*?	Y	N
Have you ever had any *laser eye treatments?*	Y	N
Have you been told you have *cataracts*?	Y	N
Have you ever had *cataract surgery*?	Y	N
Have you experienced *double vision*?	Y	N
Have you experienced any *eye injuries*?	Y	N

Have you ever had surgery?	Y	N
Are you pregnant or currently nursing?	Y	N

Medical History:

High Blood Pressure	Y	N
Thyroid Disease	Y	N
Diabetes	Y Type:	N
Arthritis	Y	N
Neurological Disorder	Y	N
Asthma	Y	N
High Cholesterol	Y	N
Heart Disease	Y	N
Bleeding Disorder	Y	N
Autoimmune Disease	Y	N
Cancer	Y	N

Medications/Vitamins/Eye drops:

Please list all current medications and vitamins; include milligrams if applicable and over the counter meds/vitamins.

_____

_____

_____

McCarthy Eye Center

Allergies:

_____

_____

Family Vision/Medical History:

Glaucoma	Y / who:	N
Blindness	Y / who:	N
High Blood Pressure	Y / who:	N
Thyroid	Y / who:	N
Autoimmune Disease	Y / who:	N
Heart Disease	Y / who:	N
Stroke	Y / who:	N
Diabetes	Y / who:	N

Social History:

Do you currently smoke?	Y	N
If yes, how much/often?	{ }	
Have you ever smoked?	Y	N
If yes, when did you quit?	{ }	
Do you drink alcohol?	Y	N
If yes, how much?	{ }	
Do you use recreational drugs	Y	N

FEE POLICIES FOR MCCARTHY EYE CENTER:

All fees pertaining to your office visit will be billed to your insurance company. Any annual deductibles are/or copayments are your responsibility and should be paid at the time of your visit. There is a refraction fee to get a prescription for glasses or contacts.

I understand that I will be held responsible for any deductibles/copayments or non-covered services by my insurance. If my account goes without payment for 90-120 days, I understand that my account will be sent to a collection agency and I will be responsible for paying an additional 30% off the fee. I understand that if I wish to get a new prescription, I will be responsible for a refraction fee if not covered by my insurance.

Consent for Medical Care and Release of Medical Records:

I give my permission for medical care, including the recording of my medical history, physical examination, laboratory tests, and x-ray films; any of which may help evaluate my condition, plan treatment, or evaluate its results. I have been informed that written and computerized records regarding my illness, treatment, follow-up will be kept by my doctors and their staff. I also understand that computer access to and/or copies of these records which may include pathology slides, x-ray and associated reports may be provided to authorize personnel at affiliated institutions where I may continue my treatment. If I wish to get a copy of my medical records, I am aware of a fee. I am aware of the fact that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me in terms of treatment of examination. My medical records may be used by McCarthy Eye Center, S.C. and/or my insurance carrier for auditing as well as billing purposes to improve the efficiency and quality of healthcare.

I am aware my pupils may need to be dilated as part of my eye examination and that I may or may not be able to drive immediately following my exam.

By signing below, I have read and understood the Fee Policies/Medical Care and Release of Medical Records.

ACKOWLEDGEMENT OF RECEIPT McCarthy Eye Center, S.C.

Notice of Privacy Practices by signing below you acknowledge that you have received a copy of our Notice of Privacy Practices.

*Signature: _____ Date: _____

Relation to patient (if not self): _____

Pharmacy Information

Prescriptions will be sent electronically. Please fill out as best you can.

Pharmacy name: _____

Pharmacy Address: _____

City: _____

Zip Code: _____

Pharmacy is crossing the streets of: _____

_____

Pharmacy Phone Number: _____

*** Only for patients under the age of 18***

Height: _____

Weight: _____