Welcome to Long Family Eye Care!

Please take a few moments to fill out this patient information sheet. It will allow us to get to know you better and assist in billing procedures and filing your insurance. **Thank you and we hope you enjoy your visit with us today!**

Patient Name:_____ Nickname:_____ Today's date_____

Address:_____Phone(h)_____(w)_____(c)_____

City_____ State_____ Zip_____

Email_____ *listing your email means you agree to receive our quarterly newsletter.

Sex: Male/Female Date of Birth_____/_____/_____ Age:_____ Social Security#_____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Domestic Partner

Employment Status: ☐ Full time ☐ Part time ☐ Student ☐ Not Employeed
Employer _____Job Title_____

Please list the names of immediate family members who are patients here:

_____

How did you hear about us?

☐ **Friend/** ☐ **Relative/** ☐ **Another Doctor, Name:** _____

☐ Saw Sign/Building / ☐ Radio/ ☐ Newspaper/ ☐ Yellow Pages/ ☐ Website/ ☐ Insurance List/ ☐ Other_____

Financially Responsible Party (if different from above)

Name_____SS#_____Relationship to Patient_____

Primary Eye Care Insurance_____ ID#_____Group#_____

Secondary Insurance_____ ID#_____ Group#_____

Patient Eye History

Date of last exam_____ by whom? _____ **Do you wear Contacts? Y/N**
Contact lens type: Rigid Gas Perm/Soft **Brand** _____ **Wear schedule:** daily/ biweekly/ monthly

Do you..... ☐ use a computer? ☐ have RX sunglasses? ☐ want information on Laser Vision Correction surgery? ☐ have an interest in the latest contacts? ☐ have colored contacts?

Have you had or been treated for... ☐ cataracts ☐ glaucoma ☐ corneal abrasion ☐ eye infection ☐ eye injury ☐ lazy eye ☐ macular degeneration ☐ retinal detachment ☐ diabetic eye problems

Have you experienced.... ☐ Blurred vision ☐ itchiness ☐ burning ☐ tearing ☐ dryness ☐ flashes of light ☐ floaters ☐ sun sensitivity ☐ trouble seeing at night ☐ uncomfortable glasses

Please list other concerns you have with your eyes or vision:

Patient Medical History

Medical Doctor_____ **Last Physical** _____ **City/State**_____

Medications (including eye drops, vitamins, non-prescription)

_____

_____

_____

Allergies to Medications? Y/N _____

Do you…use cigarettes/tobacco? Y/N Alcohol? Y/N Other substance(s)? Y/N

Have you ever been diagnosed or treated for the following? ☐llergies ☐sthma ☐rthritis ☐ancer
☐ cholesterol ☐diabetes ☐heart disease ☐high blood pressure ☐kidney ☐nerves ☐thyroid
☐ other_____

Family Medical/Eye History

Is there a family history of any of the following? Please list family member and age of onset.

Blindness ☐ _____

Glaucoma ☐ _____

Lazy Eye ☐ _____

Macular Degeneration ☐ _____

Diabetes ☐ _____

Cancer ☐ _____

Heart Disease ☐ _____

High Blood Pressure ☐ _____

Other ☐ _____

All Patients must sign below

Consent, Assignment and Release:

By my signature below, I authorize Long Family Eye Care, PC to release any information needed to determine my Medicare, Medigap/Supplement, or other insurance benefits to the Social Security Adminstration, Health Care financing Administration, or any other insurance agent. Payment of authorized benefits will be made on behalf of Long Family Eye Care, PC. My signature on this form acknowledges that I have read and understand the above, and it will also serve as my "***signature on file***".

_____ _____

Signature Date