EYEWEAR EXPRESS
PATIENT INFORMATION RECORD

Name_____Date of Birth____/____/_____
LAST, FIRST, MIDDLE,

Age_____ Gender M F Social Security #_____/____/_____

Mailing Address_____

City_____ State_____Zip_____Home Phone#_____

Parent or Guardian (minor)_____Phone#_____

Emergency Contact_____Phone#_____

Person Responsible for Payment_____Phone#_____

INSURANCE INFORMATION

Primary Insurance Carrier_____

Member Name_____DOB____/___/_____

ID#_____Group#_____Relationship to Member_____

Secondary Insurance Carrier_____

Member Name_____DOB____/___/_____

ID#_____Group#_____Relationship to Member_____

AGREEMENTS: Please initial and sign below

_____I authorize the release of any medical or other information necessary to process my insurance claims. I authorize payment of my government or private insurance benefits directly to Eyewear Express or Dr. Bradley Cross

_____I understand that I am responsible for the payment of any copays and deductibles per my insurance coverage. Payment is expected at the time of service unless other arrangements have been made in advance.

_____If I do not pay my balance due within 60 days of notification, my account will be turned over to collection agency, and I will be responsible for all collection agency fees in addition to my outstanding balance with Eyewear Express or Dr. Bradley Cross.

_____I understand that any additional testing required may be billed to my insurance as a medical procedure (i.e. Retinal Photography, Visual Field Examinations)

_____I understand the HIPPA privacy rights and have had an opportunity to review these rights.

Patient/Parent Signature_____Date_____/_____/_____

PATIENT HISTORY FORM

Please circle all applicable medical conditions
CONDITION

List all medications for this condition

EYES- Poor vision, eye pain, redness, dryness, glaucoma, cataracts, macular degeneration, other _____

ALLERGIC/IMMUNE- sneezing, swelling, itching, seasonal allergies, lupus, rheumatoid arthritis, other _____

CARDIOVASCULAR- high blood pressure, heart disease, vascular disease, stroke, other _____

CONSTITUTION- fever, fatigue, weight gain/loss, trauma, other _____

EAR/NOSE/THROAT- cold/cough, hearing loss, earache, dry mouth, other _____

ENDOCRINE- hypothyroid, hyperthyroid, diabetes, hormonal dysfunction, other _____

GASTROINTESTINAL- ulcer, digestive problem, acid reflux, crohn's disease, hernia, other _____

GENITOURINARY- STD's, impotence, painful urination, other _____

HEMATOLOGIC/LYMPHATIC- anemia, leukemia, blood transfusion, other _____

SKIN- rosacea, eczema, psoriasis, rash, other _____

MUSCULOSKELETAL- fibromyalgia, osteoarthritis, joint pain, joint replacement, other _____

NEUROLOGICAL- MS, epilepsy, headache, paralysis, other _____

PSYCHIATRIC- depression, anxiety, panic disorder, other _____

RESPIRATORY- asthma, bronchitis, emphysema, other _____

Is there a family history of Cataract, Glaucoma, Macular Degeneration, Hypertension Diabetes, Heart Disease?_____

Patient/Parent Signature_____ Date_____/_____/_____