Wood Eye Care Centers

This form must be completed in full at every visit

PATIENT INFORMATION

Last Name:____________________________First Name:___________________ Middle Initial_______

Address:__________________________________City:___________________ State:_____ Zip:_______

Sex (circle one) Male Female Date of Birth:__________________ SSN: _______________________

Home Phone:_____________________Cell phone:________________Email:______________________

Communication Preference (Circle One) Telephone Text Email Postal

Please list below individuals with whom we can communicate with about your medical history:
Name:_______________________________________Relation:_________________________________
Name:_______________________________________Relation:_________________________________

INSURANCE INFORMATION

Vision Insurance	***Medical Insurance***
Name of Insurance:_______________________	Name of Insurance:______________________
Member ID:_____________________________	Member ID:____________________________
Insured's Name: _________________________	Insured's Name: ________________________
Insured's DOB:__________________________	Insured's DOB:_________________________
SSN of Insured:__________________________	SSN of Insured:_________________________
Insured's Employer;______________________	Insured's Employer:______________________

Please Initial and Sign Below:

___ I understand that I am responsible for payment in full when services are rendered.

___ I authorize my insurance benefits to be paid directly to Wood Eyecare Centers, recognizing I am responsible for any co pays/deductibles or fees my insurance does not cover.

___ I have read and understand the Privacy Notice. (If you would like you can have a copy for your record)

Signature of Patient (or responsible party):____

Date:_____________________

MEDICAL INFORMATION:

Vision Information:
Do you wear (check applicable) ☐ Glasses ☐ Contacts ☐Both
Are you having any vision problems today? (ie blurred vision, itchy, soreness etc) ☐ No ☐ Yes (if yes, please describe)

___

Have you ever had any eye disease, eye infection, surgery, or injury? ☐No ☐ Yes
(if yes please describe)

___

Included in a comprehensive eye exam is an examination of the retina. You can choose between dilation (which is covered in the eye exam cost) or digital photography of the retina.

Would you like to be dilated today? ☐ Yes ☐ No

OR

Would you like to have retinal photography (additional fees apply)? ☐ Yes ☐ No

Social History:
Are you a smoker? ☐ Yes ☐ No ☐ Used to be
Do you regularly drink alcohol? ☐ Yes ☐No

Family Ocular History: (If yes put who in your family has had this disease)

Macular Degeneration	NO	YES	Whom:_______________
Glaucoma	NO	YES	Whom:_______________
Cataracts	NO	YES	Whom:_______________

Other:_______________

Personal Medical History:
Do you have any problems in the following areas? If yes please explain:

Cardiovascular	NO	YES_______________
Endocrine	NO	YES_______________
Gastrointestinal	NO	YES_______________
Genitourinary	NO	YES_______________
Head	NO	YES_______________
Immunology	NO	YES_______________
Lymphatic	NO	YES_______________
Muscular Skeleton	NO	YES_______________
Neurological	NO	YES_______________
Psychiatric	NO	YES_______________
Respiratory	NO	YES_______________
Skin	NO	YES_______________

Please list any other diagnosis that you may have: _______________

___

Do you take any medications ☐ Yes ☐No

If yes, please list all *medications, with dosage, frequency and route* below

Medication	**Dose** (25 mg, 100 mg etc)	**Frequency** (when needed, 1x a day etc)	**Route** (oral, drops, etc)

Do you have any allergies to medications? ☐ Yes ☐No

If yes, please list any and all drug allergies and the adverse reaction you have below.

Drug	**Reaction**