Wood Eye Care Centers

This form must be completed in full at every visit.

PATIENT INFORMATION

Last Name: _____ First Name: _____Middle:____

Address: _____ City: _____State: _____Zip:_____

Date of Birth:_____/_____/_____ Email: _____@_____

SSN: ____-____-_____(must have at least last 4 numbers for insurance claims) Sex:__Female __Male

Home Phone: (_____) _____- _____ Cell Phone: (_____) _____-_____

Communication Preference: ___Telephone ____Text ____Email ____Postal

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

Name: _____ Relation: _____Phone_____

Name: _____ Relation: _____Phone_____

INSURANCE INFORMATION

Vision Insurance

Name of Insurance:_____

Member ID: _____

Insured's Name: _____

Insured's DOB: _____

SSN of Insured: _____

Medical Insurance

Name of Insurance: _____

Member ID: _____

Insured's Name: _____

Insured's DOB: _____

SSN of Insured: _____

Note: Most insurance policies pay only a portion of your total charges. If you have any questions about your coverage, please contact your representative. We do not guarantee the accuracy of benefit information given to us by insurance companies. Please understand that financial responsibility for your account is yours, not the responsibility of your insurance company. I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical or vision benefits either to the physician or supplier of services rendered or to myself if the provider does not accept assignment. I understand that I am responsible for any balance my insurance does not pay.

MEDICAL INFORMATION:

Vision Information:

Do you wear:___Glasses ___Contacts If yes to contacts, additional fee applies for contact lens evaluation. First time contact lens wearers, must have insertion & removal training $45.

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)

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 diagnoses that you may have:

_____

Do you have any allergies to medications? _____YES _____NO
If yes, please list any and all drug allergies and the adverse reactions you have below.

Drug	Reaction

Signature: _____ Date: _____