Locations in:
*** Chillicothe** *** Brookfield**
*** Trenton** *** Carrollton**

Today Date: _____/_____/_____

Name:____ Date of Birth:_____/_____/______
(First) (Middle Initial) (Last)

SSN:_____________________ Gender: M or F Marital Status: Married / Single / Divorced / Widowed

Address:__________________________________City:_______________________State:______Zip:___________

Home Ph:_________________Work Ph:_______________Cell:______________Email:_______________________

Desired Means of Contact: ☐Home ☐Work ☐Cell ☐ Text ☐ Email Hobbies:________________________

Authorization and Release:

I authorize the release of any information; including the diagnosis and the records of any treatment or examination, to family physicians, referring physicians or for insurance purposes.

If your request for access of your health information directs us to transmit a copy of the health information directly to another person, the request must be made by you in writing, and must clearly identify the designated recipient and where to send the copy of the health information.

I authorize Premier Eyecare Associates to leave medical information pertaining to me or my dependent's care by the following method. I understand that I will assume responsibility to notify Premier Eyecare Associates whenever the information changes. ********(please circle all that apply) *********

Home Answering Machine YES / NO *Work Voicemail* YES / NO *Cell Voice Mail* YES / NO

Information will not be left with any unauthorized person who may answer the telephone.

Please list people we can discuss your or your dependent's medical care with:					
	Emergency Contact :	**Name**	**Relation**	**Ok to Discuss Info:**	**Contact Phone Number**
1)	**YES or NO**			**YES or NO**	
2)	**YES or NO**			**YES or NO**	
3)	**YES or NO**			**YES or NO**	
4)	**YES or NO**			**YES or NO**	

Acknowledgement of RECEIPT of HIPAA Notice

By initialing here ____________, I acknowledge that I have the option of receiving a copy of Premier Eyecare Associates Notice of Privacy Practices.

Authorization of Quarterly Marketing of Health-Related Letters and Newsletters

By initialing here ____________, I authorize the Premier Eyecare Associates to notify me of health-related or of non-health-related educational and informational letters and newsletters. I understand I may revoke this Authorization at any time by providing written revocation.

Consent for Treatment:

Robert D. Sloan, O.D., Duane A. Thompson, O.D., Bruce Brodmerkle, O.D., Kevin Harris, O.D., Jennifer Poston, O.D., and Premier Eyecare Associates are herewith authorized to render service, medication and treatment as necessary. I understand that a refraction may not be included on what insurance may pay. I assume full financial responsibility for any bills incurred. All items on this form have been completed and my questions about this form have been answered.

Date ___________________ Signature (representative authorized by law)____

If not patient, Print name of person signing form:________________________ Relationship to patient? ______________

MISSION STATEMENT: *Your eyes are windows to the world and our focus is to give you quality eyecare throughout a lifetime.*

☐ Check if Decline to answer the following:

Primary Language:____________________ Race: White / African American / Asian / Other:_________________

Ethnicity: Hispanic or Latino / Not Hispanic or Latino / Other: _______________________

Employer/School:______________________________ Occupation/School Grade:___________________________

Acct. Responsible Name:(required for 17-under):______________________________Phone:__________________

Insurance Information: (All information is required if filing insurance)

Name of Insurance Carrier:____________________________________ID#:___________________________

Policyholders Name:______________________________ Date of Birth:_____/_____/_____ Last 4 SS#:_______

Relationship to Patient (circle one): SELF CHILD SPOUSE OTHER:___________________

Medical Doctor (Primary Care Physician):___________________________ City:_____________________

What is the reason for your visit today?____

Approximate Date of Last Eye Exam
(Only Complete if New to Premier Eyecare):
____

How Did You Hear About Our Office:
(Only Complete if New to Premier Eyecare)

☐ Individual (Please list First & Last Name):
____

☐ Other __________________________

Glasses:

Do you wear glasses? YES / NO / SOMETIMES / WORK ONLY / READING ONLY / DRIVING ONLY

How old are your present glasses:_________________

Contacts:

Do you wear contacts? YES / NO Type:_________________ Solution Used:________________

Medications:

Please list any medications and/or drugs that you are taking (including herbal): See Attached List: ________

Medication:	For:
1)	
2)	
3)	
4)	
5)	
6)	
7)	
8)	
9)	
10)	

Patient Name: ____DOB: _____/_____/______

HEALTH HISTORY

Personal Medical History: Please check if any of the following APPLIES to you/your dependent. If you/your dependent have none of these conditions PLEASE CHECK NONE.

Cardiovascular: ____None	**Endocrine:** ____None	**Respiratory:** ____None
____ Hypertension ____ Stroke ____ Heart Disease ____ Vascular Disease ____ Other:________________________	____ Non-Insulin Dependent Diabetes ____ Insulin Dependent Diabetes ____ Thyroid Problem ____ Hormonal Dysfunction ____ Other:________________________	____ Asthma ____ Bronchitis ____ Emphysema ____ COPD ____ Other:________________________
Constitutional: ____None ____ Cancer ____ Trauma/Large Volume Blood Loss ____ Developmental Disability ____ Other:________________________	**Ocular:** ____None ____ Glaucoma ____ Macular Degeneration ____ Detached Retina ____ Other:________________________	**Psychiatric:** ____None ____ ADHD ____ Depression ____ Schizophrenia ____ Other:________________________
Neurological: ____None ____Multiple Sclerosis ____ Epilepsy ____ Cerebral Palsy ____ Tumor ____ Other:________________________	**Musculoskeletal:** ____None ____ Osteoarthritis ____ Fibromyalgia ____ Muscular Dystrophy ____ Ankylosing Spondylitis ____ Other:________________________	**Immunologic:** ____None ____ AIDS or HIV ____ Rheumatoid Arthritis ____ Lupus ____ Neurofibromatosis ____ Other:________________________
Hematological: ____None ____ Anemia ____ Leukemia ____ Other:________________________	**Gastrointetinal:** ____None ____ Crohn's ____ Colitis ____ Other:________________________	**Ear/Nose/Throat:** ____None ____ Upper Respiratory Infection ____ Other:________________________
Dermatologic: ____None ____ Eczema ____ Rosacea ____ Psoriasis ____ Other:________________________	**Allergies:** (please list) ____None ____ Drug:________________________ ________________________ ________________________ ____ Environmental	**Alcohol Use:** Y N Amount: **Tobacco Use:** Y N Amount:

FAMILY HISTORY

Has anyone in your family been diagnosed with any of the following Please check all that apply, and list who has the disease (grandparents, parents, siblings, children, living or deceased):

DISEASE / CONIDTION	**WHO**	**DISEASE / CONIDTION**	**WHO**
____ Retinal Detachment		____ Blindness	
____ High Blood Pressure		____ Cataracts	
____ Diabetes		____ Glaucoma	
____ Cancer		____ Crossed Eyes	
____ Heart Disease		____ Macular Degeneration	
____ Thyroid Disease		____ Lupus	
____ Other: ______________________		____ Other: ______________________	