Welcome To Eye Surgical Associates!

Our records contain the following information. Please correct or fill out any missing information.

Pt ID

Patient's Name: ☐ M ☐ F

First **Middle** **Last** **Salutation**

Address: **City:** **State:** **Zip:**

Home Phone: (______)____________ **Day Phone:** (_____)_____________ **Cell Phone:** (_____)___________________

Birthdate: ______________________ **Email Address:** ____

Would you like to receive electronic reminders from our office? Please circle: YES NO

Physicians

Primary Care Doctor Name, Address & Phone:

Referring Doctor Name, Address & Phone:

Optometrist's Name:_______________________________

Other Referring Specialist:_________________________

Insurance

Primary Ins:

Group #: __________

ID #: _______________

Insured: ____________ Insured Date of Birth: ________

2nd Ins:

Group #: __________

ID #: _______________

Insured: ____________ Insured Date of Birth: ________

Other Info

Patient's Employer: ________________________________

Employer Address: ________________________________

Spouse: ____

Employer:____

Emergency contact : ______________________________

Phone Number: (_______)-__________________________

Pharmacy Name & Location: ________________________

For Minor Child: Parent's Name:_____________________

Address: _____________________________________

Please specify race:

___American Indian/Alaska Native

___Asian

___Black/African American

___Native Hawaiian/Other Pacific Islander

___White

___Not Disclosed

Please specify ethnicity: ___Hispanic or Latino

___Not Hispanic or Latino

Preferred Language:____________________________

By signing below I agree to the following:

1. I authorize Eye Surgical Assoc to release any medical or other information necessary to process insurance claims.
2. You are hereby authorized to give to Eye Surgical Assoc. at 1505 Eastland Dr, Ste 2200, Bloomington IL, 61701 all information including visual fields & fundus photographs, which may be requested regarding the ocular condition or treatment rendered to me and to permit them to examine all records regarding such conditions or treatment.
3. I also request payment of government benefits to Eye Surgical Associates who accepts assignment.
4. I authorize payment of medical benefits to Eye Surgical Associates.
5. I agree to pay the costs of collection, which is the collection agency fee; and if the case is referred to an attorney for suit, the undersigned agrees to pay all court costs and reasonable attorney's fees. In addition, if any legal action is brought to enforce any provision of this agreement or to collect any amounts due under this agreement, the undersigned agrees that such legal action shall be brought in McLean County, Illinois.
6. I agree to pay a charge of $40.00 for any check payment that is returned by my bank.
7. You have permission to contact me via phone, mail, email using the information that I provided. By providing us with your wireless/cell phone number, you are hereby granting us, and our agents or independent contractors, your consent to receive calls on your wireless/cell phone number for billing and debt collection purposes.
8. I understand the HIPAA Privacy Policy of Eye Surgical Associates.

DATE:__________________ **SIGNATURE:** ____

PATIENT'S MEDICAL HISTORY QUESTIONNAIRE - Page 1

Date ____________________ Name:

What is the main reason for today's exam? ____

CURRENT EYE HISTORY:

Do you have any of the following symptoms? (with your current glasses or contact lenses)

Please Check Response	YES	NO	Please Check Response	YES	NO
Headaches	_____	_____	Drooping Eyelid	_____	_____
Glare/Light Sensitivity	_____	_____	Redness	_____	_____
Tired Eyes	_____	_____	Sandy/Gritty Feeling	_____	_____
Amblyopia (Lazy Eye)	_____	_____	Crossed Eyes	_____	_____
Burning	_____	_____	Blurred Vision at Distance	_____	_____
Dryness	_____	_____	Blurred Vision at near	_____	_____
Excess Tearing/Watering	_____	_____	Distored Vision (halos)	_____	_____
Eye Pain or Soreness	_____	_____	Double Vision	_____	_____
Foreign Body Sensation	_____	_____	Floaters or Spots	_____	_____
Infection of Eye or Lid	_____	_____	Fluctuating Vision	_____	_____
Itching	_____	_____	Loss of Vision	_____	_____
Mucous Discharge	_____	_____	Loss of Side Vision	_____	_____

Do you currently wear glasses ? _____YES _____NO

Do you currently wear contact lenses ? _____YES _____NO

Are you interested in LASIK? _____YES _____NO

At what age did you start wearing glasses?____________ / Contacts? ____________

When was your last eye exam? ____________

When did you last update your glasses prescription? ______________

Past Eye Problems or Injuries: ____

Past Eye Surgeries: ____

Current Medications: ____

Medicines that cause reactions or sensitivities: ____

Specific Allergies: ____

SOCIAL HISTORY:

Do you use nutritional supplements (vitamins, etc.)? _____YES _____NO

Do you engage in regular exercise? _____YES _____NO

Do you drink alcohol? _____YES _____NO If yes, how much: _________________

Do you smoke? _____YES _____NO If yes, how much: _________________

Have you ever smoked? _____YES _____NO When did you stop smoking? __________

What are your hobbies / Interests: ____

PATIENT'S MEDICAL HISTORY QUESTIONNAIRE - Page 2

Date ____________________ Name:

Review of Systems: **Please check any condition for which you are currently being treated.**

Constitutional Symptoms:
____Fever
____Fatigue
____Other____________

Ear, Nose, Throat, Mouth:
____Hearing Loss
____Sinus Disorders
____Other

Cardiovascular:
____Atrial Fibrillation
____Heart Disease
____Hypertension
____Stroke/TIA
____Other____________

Respiratory:
____Asthma
____Emphysema/COPD
____Shortness of Breath
____Other____________

Gastrointestinal:
____Intestinal Conditions
____Other____________

Urinary:
____Flomax Use
____Kidney Disease
____Urinary Conditions/Symptoms
____Other_________________

Musculoskeletal:
____Arthritis
____Muscle/Joint/Back Pain
____Other

Skin:
____Herpes
____Rash/Itching
____Rosacea
____Shingles
____Skin Cancer
____Other_________________

Neurological:
____Multiple Sclerosis
____Frequent Headaches
____Convulsions/Seizure
____Other_________________

Psychiatric:
____Memory Loss
____Depression
____Other____________

Endocrine:
____Diabetes
____Thyroid Disease
____Other

Blood:
____Anemia
____Cholesterol
____Other

Allergic/Immunologic:
____Seasonal Allergies
____Lupus
____Other

Other:
____Pregnant
____Nursing
____Other Conditions
____
____

IMMEDIATE FAMILY HISTORY:
Check if your Grandparents, Parents or Siblings had any of the following conditions.

Eye Diseases	**Relationship**	**Systemic Diseases**	**Relationship**
_____Amblyopia (Lazy Eye)	_____________	_____Arthritis	_____________
_____Blindness	_____________	_____Cancer	_____________
_____Cataract(s)	_____________	_____Diabetes	_____________
_____Color Blindness	_____________	_____Heart Disease	_____________
_____Eye Tumors	_____________	_____High Blood Pressure	_____________
_____Glaucoma	_____________	_____Kidney Disease	_____________
_____Glaucoma Suspect	_____________	_____Lupus	_____________
_____Macular Degeneration	_____________	_____Stroke	_____________
_____Retinal Detachment	_____________	_____Thyroid Disease	_____________
_____Strabismus (eye Turn)	_____________	_____Other Diseases	_____________
_____Other Eye conditions	_____________		

Patient Lifestyle Questionnaire

Here at Eye Surgical Associates, we strive to provide the best quality of care and customized vision solutions for our patients. This checklist will assist us in providing the treatment best suitable for your lifestyle.

1. Are you interested in Laser Cataract Surgery?

__Yes __ No

2. How important would it be for you to be free of glasses for your daily activities?

__ Very Important

__ Moderately Important

__ Not Important

__ I only want what my insurance will cover

3. Does your work or livelihood require you to drive at night?

__Yes __No

4. Please check the **one** activity below that you would most like to perform without glasses. Remember that you will likely need glasses for the other activities.

__ Reading __ Computer __Watching TV

__ Activities around the house __ Driving __Golf

5. What activities do you enjoy?

__ Crossword puzzles __ Cooking __ Swimming

__ Painting __ Needlepoint __ Reading

__ Wood working __ Tennis __ TV

__ Golf __ Gardening __ Arts and Crafts

6. How would you describe your personality?

__ Perfectionist __ In Between __ Easy Going