

## Welcome to Thomas Eye Care!

Please fill out all of the information below, making sure you complete **BOTH** sides. If you have any questions, a staff member would be happy to help!

Patient Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Responsible Party Name (mom, dad, husband, wife) :  
\_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Best Phone# \_\_\_\_\_

Is It OK to Send You Text Messages? (Please circle one)    Yes            No

Email Address: \_\_\_\_\_

Race: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status (circle): Single, Married, Divorced, Widowed, Other.

Patient Social Security Number: \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_

Employer (or School): \_\_\_\_\_ Occupation (or grade): \_\_\_\_\_

How did you hear about us? Website, Social Media, friend/family: \_\_\_\_\_  
\_\_\_\_\_

Vision Insurance: \_\_\_\_\_ Medical Insurance: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_

Policy Holder's SS#: \_\_\_\_\_ Policy Holder's DOB: \_\_\_\_\_  
\_\_\_\_\_

Previous Eye Doctor: \_\_\_\_\_ Last Eye Exam: \_\_\_\_\_

Name of primary physician: \_\_\_\_\_ Last Medical Exam: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Please list any sports or hobbies:  
\_\_\_\_\_

Allergies to medications & reactions:  
\_\_\_\_\_

Medications: (If you have a list we would be happy to make a copy)  
\_\_\_\_\_  
\_\_\_\_\_

**Please answer the following questions; Do you...**

Work at the computer for long periods? Yes / No How many hours? \_\_\_\_\_

Spend a lot of time outside? Yes / No How many hours? \_\_\_\_\_

Have prescription sunglasses? Yes/ No

Have an interest in laser vision correction? Yes / No

Have you ever worn/ currently wear contact lenses? Yes / No

If yes, what kind of contact lenses? \_\_\_\_\_

Are you interested in contact lenses? Yes/ No

**Social History (please circle)**

Never Smoked

Former Smoker, how long ago? \_\_\_\_\_.

Current Smoker? \_\_\_\_\_ PPD: \_\_\_\_\_ Yrs.

Alcohol use, amount \_\_\_\_\_, how often: \_\_\_\_\_.

Recreational drug use \_\_\_\_\_

Is patient pregnant or nursing? \_\_\_\_\_

**Family Medical History and Relationship - PLEASE LIST THE FAMILY MEMBER**

Blindness No Yes \_\_\_\_\_

Cataracts No Yes \_\_\_\_\_

Glaucoma No Yes \_\_\_\_\_

Diabetes No Yes \_\_\_\_\_

Heart Disease No Yes \_\_\_\_\_

High Blood Pressure No Yes \_\_\_\_\_

Macular Degeneration No Yes \_\_\_\_\_

Kidney Disease No Yes \_\_\_\_\_

Stroke No Yes \_\_\_\_\_

Cancer No Yes \_\_\_\_\_

Cholesterol No Yes \_\_\_\_\_

**Patient Medical History:**

Please indicate if you are currently experiencing problems/ symptoms in the following areas.

Yes    No    **PLEASE PLACE A CHECKMARK NEXT TO WHICH APPLIES**

**Constitutional**

- Fever
- Sudden weight loss
- Sudden weight gain
- Fatigue

**Ear /Nose /Throat/Mouth**

- Ulcers
- Infections
- Hearing loss

**Cardiovascular**

- Heart attack
- High cholesterol
- High blood pressure
- Stroke

Yes    No

**Respiratory**

- Cough
- Shortness of breath
- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)

**Neurological**

- Vertigo
- Tingling
- Numbness
- Headache
- Seizures

**Musculoskeletal**

- Weakness
- Joint pain
- Back pain
- Arthritis

**Endocrine**

- Hypothyroidism
- Hyperthyroidism
- Diabetes (Type 1 or Type 2? Please circle)

**Hematological/Lymphatic**

- Anemia
- Leukemia

**Allergic/Immunology**

- HIV
- Immune disorder Please specify: \_\_\_\_\_
- Seasonal allergies

**Genitourinary**

- Kidney stone
- Kidney dysfunction

**Psychiatric**

- Depression
- Anxiety
- Attention disorder

**Integumentary**

- Psoriasis
- Eczema

**Gastrointestinal**

- Colitis
- Acid reflux

**PATIENT EYE HISTORY**

**Have you ever had or are you currently experiencing any of the following?**

Yes	No	Date/Type
___	___	Eye Injury _____
___	___	Eye Surgery _____
___	___	Eye Disease _____
___	___	Amblyopia (Lazy Eye)
___	___	Cataracts
___	___	Glaucoma
___	___	Itching
___	___	Soreness
___	___	Tearing
___	___	Dryness
___	___	Eyestrain
___	___	Flashes of Light
___	___	Headaches
___	___	Redness
___	___	Double Vision
___	___	Blurry Near Vision
___	___	Blurry Distance Vision
___	___	Burning Sensation
___	___	Poor Night Vision/Glare
___	___	Sensitivity to Light
___	___	Gritty Feeling in Eye
___	___	Floaters

**(Please Sign the HIPAA Compliance Patient Consent Form on Next Page, and read over the Consent for Wellness Screening page after that. If you have any questions, any of our staff members will be happy to help!)**

## HIPAA Compliance Patient Consent Form

Please tell us with whom we are allowed to discuss and/or disclose your personal health information (**Whomever you choose must be 18 yrs of age or older**).

Please print the name(s) of the person(s), their relationship to patient, and their phone numbers.

**NAME**

**RELATIONSHIP**

**PHONE**

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My signature below authorizes the release of medical information to any specialist I may be referred to and to process insurance claims/applications, prescriptions and lab work.

I understand that under the HIPAA act, I have certain rights to privacy regarding my protected health information. I understand this information can be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment, directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practice containing a more complete description of the uses and disclosures of my health information. I understand that I may request in writing that you restrict how my private information is used and disclosed to carry out treatment, payment or health care operations.

**Patient Name (please print)**

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**Signature of patient or responsible party:**

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**Date:** \_\_\_\_\_

## INSURANCE BENEFITS AUTHORIZATION

Insurance Authorization for Assignment of Benefits and Information Release: **I, undersigned, authorize Thomas Eye Care to bill my insurance for any services furnished to me. I understand that I am financially responsible for any amount not covered by my insurance. (Copays, overages, deductible amounts, etc.)**Signature of patient/responsible party:

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**Date:** \_\_\_\_\_



## CONSENT FOR WELLNESS SCREENING

At Thomas Eye Care, we are committed to providing the highest standard of eye care. As part of our comprehensive eye exam, we include advanced screening technology to aid in the early detection of ocular diseases. These scans help us monitor your eye health and serve as a valuable comparison for future exams.

This screening includes Digital Fundus Imaging (Retinal Photos) and Optical Coherence Tomography (OCT), which provide detailed views of the retina and optic nerve, helping detect potential eye conditions early. It is recommended for all patients, especially those with the following risk factors:

- Over the age of 50
- Family history of ocular diseases such as Glaucoma or Macular Degeneration
- Diabetes or high blood pressure.

These advanced tests are not covered by vision insurance. To ensure the highest quality of care, we include them as part of ALL routine vision exams for a fee of \$50.

By signing below, I, the patient/patient guardian am consenting to this screening today as part of my routine vision exam.

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Patient Name (Print)

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Patient Signature (Or Guardian if Below Age 18)

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Date

**OR** I, the patient/patient guardian, am choosing to opt out of the above wellness screening. I understand that opting out of this screening can result in not receiving an early detection of ocular diseases.

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Patient Name (Print)

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Patient Signature (Or Guardian if Below Age 18)

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Date