

ASHLAND EYECARE



Name: (Last) _____ (First) _____ (MI) _____

Address _____ City _____ State _____ Zip _____

Social Security # _____ Date of Birth ____/____/____ Gender: M F

Home Phone (____) _____ - _____ Business Phone (____) _____ - _____ Cellular (____) _____ - _____

Employer _____ Occupation _____

Address _____ City _____ State _____ Zip _____

E-mail Address _____ Referred by _____

Vision Ins. Co. _____ Health Ins. Co. _____

In Case of Emergency notify: _____ Phone (____) _____ - _____

Marital Status (please circle): Married Single Other Family Physician _____

Parent or Individual Responsible for Payment (not Insurance Co.) _____

Address _____ City _____ State _____ Zip _____

Current Medications:

Medications reviewed: Initial and date: _____

CASE HISTORY: Subjective Data

Review of Systems: Initial and date _____

Allergic/Immunologic Neg. ____	Ears, Nose, Mouth & Throat Neg. ____	Gastrointestinal Neg. ____	Musculoskeletal Neg. ____	Sleep Disorders Neg. ____
drug allergy	Upper Resp. Tract Infect	Crohn's	fibromyalgia	sleep apnea
seasonal allergy		IBS	muscular dystrophy	
hayfever		ulcer	osteoarthritis	
rheumatoid arthritis	Endocrine Neg. ____	digestive		
lupus	non-insulin dep. diabetes		Neurological Neg. ____	ROS Changes Noted:
	insulin dependent diabetes		multiple sclerosis	
Cardiovascular Neg. ____	thyroid dysfunction	Genitourinary Neg. ____	epilepsy	
heart disease	hormonal dysfunction	STD- viral herpetic, Chlamydia		
hypertension			Psychiatric Neg. ____	
cholesterol	Eyes Neg. ____	Hematologic/Lymphatic Neg. ____	depression	
stroke	GLC	anemia	panic disorder	
vascular disease	CAT	leukemia	schizophrenia	
Constitutional Neg. ____	AMD	Integumentary Neg. ____	Respiratory Neg. ____	
developmental disability	surgery	eczema	asthma	
fatigue	inflammatory disorders	rosacea	bronchitis	
trauma	injury	psoriasis	emphysema	

FAMILY HISTORY: Subjective Data

Ocular: + - GLAUCOMA + - CATARACT + - MACULAR DEGENERATION + - EYETURN
Medical: + - HYPERTENSION + - DIABETES + - THYROID

Medicare: Did patient sign Advance Beneficiary Notice (ABN)? Yes No

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above mentioned companies and assign directly to Ashland Eyecare, Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I authorize use of my signature on all insurance submissions. **I acknowledge that I am financially responsible for all unpaid debt as a result of services performed at this facility, as well as payment for procedures that my policy will not cover.** Ashland Eyecare, Inc. will not be held liable for quote of vision benefits given by my insurance company as the quote is not a guarantee of payment. To the extent necessary to determine liability for payment, and to obtain reimbursement, I authorize disclosure of portions of my medical records.

Signature _____ Date _____