

# ASHLAND EYECARE



Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender: M F

Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_\_ 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 \_\_\_\_\_

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

**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 \_\_\_\_\_