MARTIN EYE CARE
We Focus on CARE.

Patient Information

Today's Date:_______________

First Name:__________________ MI:_____ Last Name:__________________ Soc. Sec. #:________________

Address:___________________________ City:__________________ State:_______ Zip Code:______________

Email Address:____ Date of Birth:__________________

Cell Phone #: __________________ Home Phone #:__________________ Age:__________________

Work Phone #:__________________ Emergency Contact:_____________________ Phone #:________________

Occupation:____________________________________ Employer:_____________________________________

Marital Status: Single:_________ Married:________ Divorced:________ Separated:_________ Widowed:_________

Spouse's Name:_____________ If minor - Parent Name:___________________ Parent Date of Birth:___________ If new to office, whom shall we thank for referring you:____

If not referred, how did you hear about our office:____

Primary Care Physician:___________________________________ City:_________________________________

Medications: Provide List:______ or List Here:____

____

Allergies (medications/substances) :____

Do You: Smoke: Yes______ No______ Use Alcohol: Yes______ No______ Other Substances: Yes______ No______

Insurance Information *(Please give all insurance cards to receptionist to copy for your file and billing)*

Medical Insurance:_________________________

Member's Name:__________________________

Member's Date of Birth:___________________

Policy ID#:______________________________

Patient's Relationship to Member:_______________

Secondary Medical Insurance:_______________________

Member's Name:______________________________

Member's Date of Birth:____________________________

Policy ID#:__________________________________

Patient's Relationship to Member:___________________

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Vision Insurance:__________________________

Member's Name:__________________________

Member's Date of Birth:___________________

Member's last 4 digits of Soc. Sec. #__________

Policy ID#:______________________________

Patient's Relationship to Member:_________________

Secondary Vision Insurance:_______________________

Member's Name:______________________________

Member's Date of Birth:____________________________

Member's last 4 digits of Soc. Sec. #__________________

Policy ID#:__________________________________

Patient's Relationship to Member:__________________

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Martin Eye Care. I understand that I am financially responsible for any balance. I also authorize Martin Eye Care or insurance company to release any information. Fees and/or copays for professional services are due the day the service is provided. A minimum of 50% down or copay is required to order materials. A returned check will be charged a service fee of $25.00.

Signature:________________________________ Date:_____________

Updated Date:____________	Updated Date:____________	Updated Date:____________	Updated Date:____________	Updated Date:____________
No Changes Date:__________	No Changes Date:__________	No Changes Date:__________	No Changes Date:__________	No Changes Date:__________
Patient Initials:__________	Patient Initials:__________	Patient Initials:__________	Patient Initials:__________	Patient Initials:__________

NOTICE OF PRIVACY PRACTICES: I have received a separate document titled "Notice of Privacy Practices" that describes how my protected health information is used and disclosed. **Patient Initials: ___________ Date: ___________**

RELEASE OF INFORMATION: I authorize Martin Eye Care PLLC to discuss my medical information with:

Primary Care Physician: Yes____ No____ If yes, name: ____

Spouse: Yes____ No____ If yes, name: ____

Other: Yes____ No____ If yes, name(s): ____

Patient/Parent Signature: ______________________________________ Date: ________________________

REVIEW OF SYSTEM (please complete)

PROBLEMS:	**YES**	**NO**	**IF YES, PLEASE EXPLAIN**
ES:			
• Eye injury			
• Eye pain			
• Eye surgery			
• Blurred vision/loss of vision			
• Tired Eyes			
• Redness			
• Itching			
• Burning			
• Sandy feeling or dry eyes			
• Excessive tears (watery eyes)			
• Vision disturbance (spots, halos, flashes of light)			
• Light sensitivity / glare			
• Double vision			
• Glaucoma			
• Cataract			
• Macular degeneration			
• Amblyopia (lazy eye)			
• Eye turn (eso- or exotropia)			
• Keratoconus			
• Learning disability			
nstitutional (fever, weight loss)			
r, nose, mouth, throat (sinus, chronic cough, etc.)			
spiratory (asthma, emphysema, etc.)			
rdiovascular (high blood pressure, heart disease, :.)			
istrointestinal (diarrhea, constipation, ulcers, etc.)			
enitourinary (genitals, kidney ,bladder)			
uscles/Bones/Joints (arthritis, etc.)			
docrine (diabetes, thyroid, etc.)			
ychiatric (anxiety, depression, etc.)			
ood, Lymph (anemia, high cholesterol)			
ergic / Immunological (hay fever, lupus, etc.)			
in			
EUROLOGICAL:			
• Headaches			
• Other (migraines, MS, seizures, etc.)			
ncer			

EVIEWED BY/DATE: _________________ _________________ _________________ _________________ _______________