Crossroads Family Eyecare

Name: _____ Date: _____

Address: _____ City: _____

Zip: _____ Date of Birth: ___/____/____ Social Security Number: _____

Home Phone:_____ Cell Phone: _____

Work Phone: _____ E-mail: _____

Spouse's Name: _____ Spouse's Date of Birth: _____

Last 4 Digits of SSN: _____ Name of Insurance Policy Holder: _____

Review of Systems: (please circle all that apply)

1. Constitution – Developmental Disabilities, Cancer, Fatigue Syndrome other: _____
2. Ear/Nose/Throat – Hearing loss, Sinus Problems, Dry Mouth, Laryngitis other: _____
3. Neurological – MS, Epilepsy, Cerebral Palsy, Tumor, **Stroke**, Migraine other: _____
4. Psychiatric – Depression, Attention Deficit, Anxiety Disorder, Bipolar Disorder other: _____
5. Cardiovascular – **High Blood Pressure** (hypertension), Heart Disease, Vascular Disease, Congestive Heart Failure, **Heart Attack** other: _____
6. Respiratory – Cigarette Smoker, Asthma, Bronchitis, Emphysema, Chronic Obstruction, Sleep Apnea other: _____
7. Gastro Intestinal – Crohn's, Colitis, Ulcer, Acid Reflux, Celiac Disease other: _____
8. Genitourinary – Kidney Disease, Prostate Disease, Prostate Cancer, STD (Herpetic or Chlamydia), Benign Prostate Hypertrophy, Pregnant/Nursing other: _____
9. Muscular/Skeletal – Arthritis, Osteoarthritis, Fibromyalgia, Muscular Dystrophy, Ankylosing Spondylitis, Osteoporosis, Gout other: _____
10. Dermatologic – Eczema, Rosacea, Psoriasis, Herpes Simplex (cold sore), Herpes Zoster (shingles) other: _____
11. Endocrinology – **Type 2 Diabetes, Type 1 Diabetes, Thyroid Dysfunction,** Hormonal Dysfunction other: _____
12. Hematological/Lymphatic - Anemia, Large Volume Blood Loss, Ulcer, High Cholesterol other: _____
13. Allergy/Immunologic – Drug Allergies, Environmental Allergies, Rheumatoid Arthritis, Lupus, Sjogren's Syndrome other: _____

Medications and Usage: (dosages as well) Example: **Lisinopril = High Blood Pressure**

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

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Drug Allergies:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list previous ocular conditions: _____

Do you wear glasses? ___ yes ___ no

Do you wear contacts? ___ yes ___ no

Social History: Do you drink alcohol? _____ yes _____ no If yes, how often: _____

Do you smoke? _____ yes _____ no If yes, how often: _____

Hobbies: _____

Primary Care Physician: _____ Phone: _____

Family Medical History: (please circle all that apply)

Cancer	Father	Mother	Brother	Sister	Son	Daughter	Other: _____
Diabetes Type 1	Father	Mother	Brother	Sister	Son	Daughter	Other: _____
Diabetes Type 2	Father	Mother	Brother	Sister	Son	Daughter	Other: _____
Hypertension	Father	Mother	Brother	Sister	Son	Daughter	Other: _____
Hyperthyroidism	Father	Mother	Brother	Sister	Son	Daughter	Other: _____
Hypothyroidism	Father	Mother	Brother	Sister	Son	Daughter	Other: _____

Family Ocular History: (please circle all that apply)

Cataract	Father	Mother	Brother	Sister	Son	Daughter	Other: _____
Macular Degenerative	Father	Mother	Brother	Sister	Son	Daughter	Other: _____
Glaucoma	Father	Mother	Brother	Sister	Son	Daughter	Other: _____

How did you hear about us? (please circle all that apply)

Friend or Family who: _____ Website Facebook

PROCEDURES MAY BE INDICATED AND DISCUSSED THAT EXCEED THE MINIMUM THAT IS APPROVED BY INSURANCE

(IF INSURED ___ **I DO** authorize those services today. I want complete and optimal eye care even if I incur out of pocket costs.
Check One) ___ **I DO NOT** authorize those services today, I do not want extra out of pocket costs, so limit my care to what should be covered.

I authorize and consent to the examination and treatment of the above patient. I certify that the above information is correct. I authorize the doctor to release any information needed to process my insurance claims and I assign payment to the provider of any benefits. I am responsible for fees incurred and any additional cost of collection including reasonable attorney's fees and interest at 2% per month on any unpaid balance on this account and I agree to promptly pay amounts due when incurred or upon insurance denial.

PLEASE SIGN HERE: _____ **DATE:** _____