Eye Exams * Glasses * Contact Lenses * Glaucoma
Lasik Consultation * Vision Therapy

7035 Barker Cypress * Cypress, Texas 77433
Phone: 281.550.4141 * Web: www.cfeyecare.com

Patient Information

Date of Appointment ______________________

Age _____ Birth Date ______________________

Patient Name ______________________

Nickname______________________

Address ______________________

City__________________State_______Zip______________

Gender ___M ___ F

Patient SS# ______________________

Marital Status______________________

Email______________________

___Employed ___Full-Time Student ___Retired

Employer ______________________

Occupation______________________

If this is your first visit how did you hear about our clinic?

____

____

Insurance Information

Who is responsible for this account? (Policy Holder)

____

Relationship to Patient ______________________

Birth Date ______________________

Medical Insurance Company:

____

ID#______________________

Group#______________________

Vision Plan ______________________

SS# or ID# ______________________

***Please bring both medical and vision cards to your visit.**

Phone Numbers

Home______________________

Work ______________________

Mobile______________________

Preferred Contact Method ______________________

What is the purpose of your visit? ______________________

Are you planning to get new glasses today?	Yes	No	Only if Rx changes
Are you planning to get new contacts today?	Yes	No	Only if Rx changes
Are you interested in finding out more about Lasik?	Yes	No	Maybe
What is your primary vision correction?	Glasses	Contacts	None

INSURANCE AUTHORIZATION

I request that payment of authorized insurance benefits be made to Dr. James Oevermann for any services furnished me by that doctor. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If “other insurance” is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier**. I understand that I am financially responsible for all charges not paid by my insurance company.** I authorize the use of this signature on all insurance submissions.

______________________ ______________________
Signature of Beneficiary Today’s Date

HEALTH HISTORY

Circle" Yes" or "No" to indicate if you have had any of the following. Circle "Yes" or "No" under family members to indicate if a blood relative has had any of the following.

	Yourself		Family			Yourself			Yourself	
Blindness	Yes	No	Yes	No	Weight Gain	Yes	No	Diarrhea	Yes	No
Cataract	Yes	No	Yes	No	Skin Problems	Yes	No	Constipation	Yes	No
Crossed Eyes	Yes	No	Yes	No	Headaches	Yes	No	Kidney/Bladder	Yes	No
Glaucoma	Yes	No	Yes	No	Migraines	Yes	No	Heart Pain	Yes	No
Macular Degeneration	Yes	No	Yes	No	Seizures	Yes	No	Muscle Pain	Yes	No
Retinal Detachment	Yes	No	Yes	No	Thyroid	Yes	No	Joint Pain	Yes	No
Retinal Disease	Yes	No	Yes	No	Allergies/Hay Fever	Yes	No	Anemia	Yes	No
Arthritis	Yes	No	Yes	No	Sinus Congestion	Yes	No	Bleeding Problems	Yes	No
Cancer	Yes	No	Yes	No	Runny Nose	Yes	No	Fever	Yes	No
Diabetes	Yes	No	Yes	No	Dry Mouth/ Throat	Yes	No	Psychiatric	Yes	No
Heart Disease	Yes	No	Yes	No	Asthma	Yes	No	Chronic Bronchitis	Yes	No
High Blood Pressure	Yes	No	Yes	No	Emphysema	Yes	No	Vascular Disease	Yes	No
Kidney Disease	Yes	No	Yes	No	Other ____________________					
Lupus	Yes	No	Yes	No	Are you Pregnant?	Yes	No	Number of Children ________		
Thyroid Disease	Yes	No	Yes	No	Tobacco use	Yes	No	Alcohol Use	Yes	No

EYE HEALTH HISTORY

Circle "Yes" or "No" to indicate if you currently have or ever had any of the following:

Blurred Vision- Distance	Yes	No	Floaters or Spots	Yes	No	Bloodshot Eyes	Yes	No	Watering Eyes	Yes	No
Blurred Vision- Near	Yes	No	Poor Vision	Yes	No	Burning Eyes	Yes	No	Itching Eyes	Yes	No
Light Sensitive	Yes	No	Fainting, Blackouts	Yes	No	Poor Color Vision	Yes	No	Loss of Vision	Yes	No
Crossed Eyes	Yes	No	Discharge from Eyes	Yes	No	Dizzy Spells	Yes	No	Red Eyes	Yes	No
Double Vision	Yes	No	Seeing Halos	Yes	No	Dry Eyes	Yes	No	Seeing Flashes	Yes	No
Eye Infection	Yes	No	Temporary Vision Loss	Yes	No	Eye Injury	Yes	No	Twitching Eyelid	Yes	No
Eye Strain	Yes	No	Poor Night Vision	Yes	No						

Medications

List all medications you are currently taking including eye drops ____

____

____

Allergies

List any allergies to medications or other substances ____

____

Signature of Patient____ Date__________________

Signature of Responsible Party____ Date__________________