CTR EYE CARE

MR _____

Patient Information

Patient Name	Date of Birth	Birth Gender ☐ M ☐ F	Marital Status
Mailing Address	City/State/Zip		
Home Phone	Cell Phone		
Email Address	Social Security #		
Reminder Preference ☐ Home Phone ☐ Cell Phone Call ☐ Cel Phone Text ☐ eMail	Primary Care Physician	Referring Physician	
Race ☐ American Indian / Alaska Native ☐ Asian ☐ Prefer not to answer ☐ Black/African American ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other _____	Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Prefer not to answer		
	Preferred Language	Diabetic ☐ Yes ☐ No	

Personal Representative (Spouse, Child, Care Giver) ☐ I decline

This allows us to give information regarding your protected health information, including appointments, diagnosis, financial, etc., in your behalf.

Name	Relationship
Home Phone	Cel Phone

Guarantor/Responsible Party (person responsible for payment)

Legal Name	Date of Birth	Phone

Medical Insurance (please present your ID and insurance card to receptioninst)

Primary Insurance Company Name	Policy Number / Member ID	Group Number
Policy Holder / Subscriber	Policy Holder Date of Birth	Patient Relationship to Policy Holder
Insurance Address (usually on back of insurance card)		Phone
Secondary Insurance Company Name	Policy Number / Member ID	Group Number
Policy Holder / Subscriber	Policy Holder Date of Birth	Patient Relationship to Policy Holder
Insurance Address (usually on back of insurance card)		Phone

Financial Agreement and Consent

I authorize Central Utah Eye to provide information to my insurance company, Medicare, medical provider and others who are legally entitled. I authorize reports of my evaluation, treatments and any follow up evaluations to be sent to my referring physician, optometrist, consulting physician, my primary care physician and any health care providers that I have or will identify to Central Utah Eye. I also authorize release of all pertinent medical information to any hospital, outpatient facility or clinic. Photography may be used in the evaluation and management of my condition; I consent to the taking of such photographs.

By signing below, I am stating that I understand that I am fully and legally responsible for payments of the account which includes all outstanding balances not covered by Medicare and/or insurance companies. We refer to "in network" as the insurance companies that we have a contract agreement with. It is your responsibility to check your insurance company for coverage and participation details. We will submit insurance claims on your behalf to your primary insurance and secondary insurance carrier.

Central Utah Eye believes that a good physician / patient relationship is based on understanding and communication. By signing below I also agree to pay all amount(s) owed within 30 days of when such amount(s) are incurred.

I acknowledge that I may ask at any time to receive a copy of the Privacy Practices for Central Utah Eye.

_____ _____

Patient / Guarantor's Signature Date

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MR_____

Patient Name:

Reason for Visit: _____ Weight: _____ Height: _____

Referring Physician: _____ Women: Are you pregnant? ☐ Yes ☐ No

Pharmacy: _____ Flu Vaccine? ☐ Yes ☐ No

Pneumonia Vaccine? ☐ Yes ☐ No

Allergies ☐ None

List medical, food, latex and environmental allergies.

_____ _____ _____

_____ _____ _____

Ocular History & Surgery ☐ None

Check any that you have been diagnosed with in the past. If yes, please list date and which eye.

- ☐ Cataract Surgery _____
- ☐ Cornea Disease _____
- ☐ Diabetic Retinopathy _____
- ☐ Dry Eye _____
- ☐ falso
- ☐ Glaucoma _____
- ☐ Iritis / Uveitis _____
- ☐ Macular Degeneration _____
- ☐ Retinal Disease
- ☐ Other Eye Condition: _____

Medications ☐ None

List all current medications. Use back side if more space is needed.

_____ _____ _____

_____ _____ _____

Health Conditions ☐ None

Check any conditions you are currently being treated for or have had in the past:

- ☐ Arthritis
- ☐ Anemia
- ☐ Asthma or Lung Disease
- ☐ Bleeding Disorder
- ☐ Cancer _____
- ☐ Diabetes T1 / T2 (circle)
- ☐ Falls - 2 or more in the last year
- ☐ Heart Disease: Pacemaker / Defibrillator (circl
- ☐ Hepatitis A / B / C (circle)
- ☐ Herpes Simplex / Zoster Shingles (circle)
- ☐ HIV: CD4 Count _____
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Liver Disease or Hepatitis
- ☐ Lung Disorder
- ☐ Lupus _____
- ☐ Migraines / Headaches
- ☐ Psychiatric Disorder
- ☐ Seizures Convulsion or Fainting
- ☐ Stroke
- ☐ Syphilis
- ☐ Thyroid Disease
- ☐ Other Diagnosed Health Problems:

Surgeries ☐ None

List all surgeries. Use back side if more space is needed.

_____ _____ _____

_____ _____ _____

Family History ☐ None

Check if any of your BLOOD relatives have had the following and list relationship (Parent, Aunt, Etc.)

- ☐ Blindness _____
- ☐ Cancer, type_____
- ☐ Cataracts _____
- ☐ Diabetes _____
- ☐ Glaucoma _____
- ☐ Heart Disease _____
- ☐ High Blood Pressure _____
- ☐ Kidney Disease _____
- ☐ Lazy Eye _____
- ☐ Macular Degeneration _____
- ☐ Retinal Disease _____
- ☐ Stroke _____

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MR_____

Patient Name:

Eyes

Previous Surgery	☐ YES	☐ NO
Contact Lens	☐ YES	☐ NO
Pain	☐ YES	☐ NO
Double Vision	☐ YES	☐ NO
Glaucoma	☐ YES	☐ NO
Cataracts	☐ YES	☐ NO
Macular Degeneration	☐ YES	☐ NO
Dry Eyes	☐ YES	☐ NO
Flashes	☐ YES	☐ NO
Floaters	☐ YES	☐ NO

Ear, Nose and Throat

Hard of Hearing	☐ YES	☐ NO
Ringing in Ears	☐ YES	☐ NO
Vertigo	☐ YES	☐ NO

Cardiovascular

Chest Pain	☐ YES	☐ NO
Dizziness	☐ YES	☐ NO
Fainting Spells	☐ YES	☐ NO
Shortness of Breath	☐ YES	☐ NO
Irregular Heart Beat	☐ YES	☐ NO
Difficulty Lying Flat	☐ YES	☐ NO

Constitutional

Fatigue / Weakness	☐ YES	☐ NO
Fever	☐ YES	☐ NO
Weight Gain / Loss	☐ YES	☐ NO

Respiratory

Cough	☐ YES	☐ NO
Congestion	☐ YES	☐ NO
Wheezing	☐ YES	☐ NO
Asthma	☐ YES	☐ NO

Gastrointestinal

Heartburn	☐ YES	☐ NO
Nausea / Vomiting	☐ YES	☐ NO
Jaundice / Hepatitis	☐ YES	☐ NO

Genito-Urinary

Pain / Difficulty	☐ YES	☐ NO
Blood in Urine	☐ YES	☐ NO
History of Kidney Stones	☐ YES	☐ NO
History of STD's	☐ YES	☐ NO

Psychiatric

Anxiety / Depression	☐ YES	☐ NO
Mood Swings	☐ YES	☐ NO
Difficulty Sleeping	☐ YES	☐ NO

Endocrine

Increased Thirst	☐ YES	☐ NO
Increased Hunger	☐ YES	☐ NO
Increased Urination	☐ YES	☐ NO
Increased Sweating	☐ YES	☐ NO
Fingernail Changes	☐ YES	☐ NO

Blood / Lymph Nodes

Easy Bruising	☐ YES	☐ NO
Gums Bleed Easily	☐ YES	☐ NO
Prolonged Bleeding	☐ YES	☐ NO
Heavy Aspirin Use	☐ YES	☐ NO

MusculoSkeletal

Stiffness	☐ YES	☐ NO
Arthritis	☐ YES	☐ NO
Joint Pain / Swelling	☐ YES	☐ NO
More than 2 falls in last year	☐ YES	☐ NO

Skin

Rash / Sores	☐ YES	☐ NO
Lesions	☐ YES	☐ NO
Hives / Eczema	☐ YES	☐ NO

Neurological

Seizures	☐ YES	☐ NO
Weakness / Paralysis	☐ YES	☐ NO
Numbness	☐ YES	☐ NO
Tremors	☐ YES	☐ NO

Immunologic

Hives	☐ YES	☐ NO
Itching	☐ YES	☐ NO
Runny Nose	☐ YES	☐ NO
Sinus Pressure	☐ YES	☐ NO

Social History

Drink Alcohol ☐ YES ☐ NO

How Much:

☐ Occasionally ☐ Socially ☐ More than 2x Daily

Drug Use ☐ YES ☐ NO

Which Drug: _____

Smoker

☐ Current every day ☐ Former

☐ Current some days ☐ Never

Hobbies _____

_____

How did you hear about us?

☐ Other: _____

☐ Newspaper/Ad

☐ Social media

☐ Radio