



# TAYLORMADE

EYECARE & OPTICAL

Today's Date: \_\_\_/\_\_\_/\_\_\_

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ Social Security#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex: \_\_\_ Male \_\_\_ Female  
 Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
 Email Address: \_\_\_\_\_ (Kept absolutely confidential-used only for appt. reminders, etc)  
 If patient is a minor, please supply parental/guardian(s) name(s): \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Marital Status: \_\_\_ Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed  
 Spouse's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

### How did you first become aware of our practice?

\_\_\_ Friend or Family (Name): \_\_\_\_\_ \_\_\_ Practice Website \_\_\_ Direct Mail \_\_\_ Yellow Pages  
 \_\_\_ Medical Doctor (Name): \_\_\_\_\_ \_\_\_ Insurance Company \_\_\_ Drive By \_\_\_ Other

## INSURANCE INFORMATION

VISION Insurance Co.: \_\_\_\_\_ MEDICAL Insurance Co.: \_\_\_\_\_  
 Insured Member Name: \_\_\_\_\_ Patient Relation to Insured: \_\_\_\_\_  
 Identification # \_\_\_\_\_ Group # \_\_\_\_\_  
 Insured Member Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Insured Date of Birth \_\_\_/\_\_\_/\_\_\_

### PLEASE SIGN THE FOLLOWING STATEMENT WHICH ALLOWS DR. TAYLOR TO FILE WITH YOUR INSURANCE COMPANY:

I, the undersigned, certify that I (or my dependent) have insurance coverage with the company previously listed, and assign all insurance benefits directly to Dr. Christy Taylor/TaylorMade Eyecare & Optical. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature for all insurance submissions.

SIGNED: \_\_\_\_\_ DATE: \_\_\_/\_\_\_/\_\_\_

### HIPAA ACKNOWLEDGEMENT: My signature below indicates that I have received, reviewed, and understand my right to privacy under HIPAA guidelines.

\_\_\_ I have received a copy. \_\_\_ I waived my right to a copy. SIGNED: \_\_\_\_\_ DATE: \_\_\_/\_\_\_/\_\_\_

## EYE HEALTH HISTORY

Date of Last Eye Exam: \_\_\_\_\_ Name of Eye Doctor or Location: \_\_\_\_\_

Please mark any problems below that you are currently experiencing:

___ Blind Spot(s) in Vision	___ Crossed Eyes	___ Floaters	___ Loss of Vision-Temp	___ Red Eyes
___ Blurred Vision-Distance	___ Dizzy Spells	___ Glaucoma	___ Macular Degeneration	___ Seeing Flashes
___ Blurred Vision-Intermediate	___ Double Vision	___ Headaches	___ Migraines	___ Seeing Halos
___ Blurred Vision-Near	___ Dry Eyes	___ Itchy Eyes	___ Mucous Discharge	___ Sty(e)s
___ Burning Eyes	___ Eye Injury	___ Light Sensitivity	___ Painful Eye(s)	___ Twitching Eyelid
___ Cataract(s)	___ Eye Strain	___ Loss of Vision-Constant	___ Poor Night Vision	___ Watery Eyes

## EYE HEALTH HISTORY-CONTINUED

Are you interested in learning more about LASIK or other corrective surgical procedures?  Yes  No

How many total hours per day do you spend at a computer? \_\_\_\_\_ How many days per week? \_\_\_\_\_

Please mark any of the following symptoms notices after extended computer use:

Blurred Vision  Eyestrain  Dry Eyes  Glare Sensitivity  Headaches  Neck/Backaches  Distance Vision Blurred

**Do you wear glasses?**  Yes  No

If **YES**, do you wear them:  Full-time  Part-time  Distance Only  Near Only

What type of lenses?  Single Vision  Progressive  Lined Bifocal  Safety Glasses  Other

**Do you wear contact lenses?**  Yes  No

If **YES**, please answer the following questions:

What brand or type of contact lenses do you wear? \_\_\_\_\_ How old are your current lenses? \_\_\_\_\_

How often do you replace your lenses? \_\_\_\_\_ What is your normal wear schedule? \_\_\_\_\_ hours/day \_\_\_\_\_ days/week

Are you having any problems with your contact lenses?  Dry out easily  Uncomfortable  Blurry Far Vision  Blurry Near Vision

What brand of solution do your lenses soak in at night? \_\_\_\_\_

Do your back-up glasses have your current prescription?  Yes  No  I do not have back-up glasses

If you **DO NOT** wear contact lenses, please mark any of the following statements that apply to you:

I have had LASIK or other corrective surgery  I have been told that I can't wear contact lenses because I have astigmatism or reading problems

I have worn contacts but stopped due to comfort/vision problems  I have worn contacts but stopped because they were too much trouble

I have never worn contacts but would like more information

## MEDICAL HISTORY

Date of last medical exam: \_\_\_\_\_ Name of primary care physician: \_\_\_\_\_

**Please mark any of the following health conditions that apply to you OR your family (indicate which family members):**

	<u>SELF</u>	<u>FAMILY</u>		<u>SELF</u>	<u>FAMILY</u>		<u>SELF</u>	<u>FAMILY</u>
Blindness	___	___	Bleeding Disorder	___	___	Hepatitis (Type___)	___	___
Glaucoma	___	___	Cancer	___	___	High Blood Pressure	___	___
Lazy Eye	___	___	Diabetes	___	___	Kidney Disease	___	___
Macular Degeneration	___	___	Emphysema	___	___	Lupus	___	___
Retinal Disease	___	___	Epilepsy/Seizures	___	___	Shingles	___	___
Turned Eye	___	___	Fibromyalgia	___	___	Stroke	___	___
AIDS/HIV+	___	___	Hay Fever	___	___	Thyroid Conditions	___	___
Arthritis	___	___	Heart Condition	___	___	Tuberculosis	___	___

How long have you been treated for any of the above conditions? \_\_\_\_\_

Please describe any major surgeries/year performed: \_\_\_\_\_

Are you pregnant?  If YES, how many months? \_\_\_\_\_ Gestational Diabetes?  Do you smoke?  How many packs/day? \_\_\_\_\_

If you are diabetic: How often do you check your glucose? \_\_\_\_\_ Average glucose level: \_\_\_\_\_ A1C Level: \_\_\_\_\_

**CURRENT MEDICATIONS:**

Include over-the-counter AND prescription drugs:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**ALLERGIES:**

Include food AND drug allergies:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## MEDICARE/MEDIGAP AUTHORIZATION (IF APPLICABLE)

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Dr. Christy Taylor for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents to any information needed to determine these benefits or benefits for related services.

Signature of Beneficiary, Guardian or Personal Representative \_\_\_\_\_

Date \_\_\_\_\_

Please print name of Beneficiary, Guardian or Personal Representative \_\_\_\_\_

Relationship to Beneficiary \_\_\_\_\_