Eye Care Plus, LLC

☐ **2474 Cross Pointe Dr., Rock Hill, SC 29730 (P) 803-329-3937**
☐ **175 Hwy 274 Lake Wylie SC 29710 (P) 803-831-0067**

Date: _____
Patient Name First: _____Middle_____Last_____
Address_____
City _____State _____ZIP Code _____
Date of Birth _____Age_____ Social Security # _____
Work/Cell _____ Home Phone_____
E-mail address _____
Sex: M or F Marital Status: Single Married Widowed Divorced
Patient Occupation_____
Spouse Name _____ DOB_____
Spouse Phone_____
Emergency Contact Person _____
Relationship to you _____ Phone _____
Do you have a medical power of attorney or legal guardian? Y N
POA or Guardians name and phone number _____
(PLEASE BRING IN OR FAX A COPY OF THIS PAPERWORK ASAP)
****
Primary Insurance/ID#_____
Subscriber Name _____
Subscriber Date of Birth _____
Subscriber Social Security # _____
Secondary Insurance/ID# _____
Subscriber Name _____
Subscriber Date of Birth _____
Subscriber Social Security # _____
Third Insurance/ID# _____
Subscriber Name _____
Subscriber Date of Birth _____
Subscriber Social Security # _____
****
Is your visit Work/Auto accident related? Y/N Date Accident Occurred _____
Have you reported the incident? Y/N Claim#/Contact _____

Reason for Today's Visit : _____

Eye History

Cataracts	Y N	Lazy Eye	Y N	Dry Eyes	Y N
Retinal Detachment	Y N	Diabetic Eye Problems	Y N	Macular Degeneration	Y N
Crossed Eyes	Y N	Lasik	Y N	Color Blindness	Y N
Glaucoma	Y N	Laser Treatment	Y N	Double Vision	Y N
Blurred Vision	Y N	Glare Problems	Y N	Floaters or Flashes	Y N
Redness or Itching	Y N	Burning or Discharge	Y N	Light Sensitive	Y N

Do you have a **Family History** of: Glaucoma Y N, Macular Degeneration Y N, Retinal Detachment Y N

Eye Surgeries: _____

Eye Medications: _____

Do you wear glasses: Y N

Do you wear Contact Lenses Y N Brand & Strength _____

Medical History	Self	Family		Self	Family
AIDS/HIV	Y N	Y N	Lung Disease (Asthma, COPD)	Y N	Y N
Arthritis	Y N	Y N	Migraine headaches	Y N	Y N
Kidney Disease	Y N	Y N	Heart Disease	Y N	Y N
Bleeding	Y N	Y N	Stroke	Y N	Y N
Cancer(type:)	Y N	Y N	Pacemaker	Y N	Y N
Diabetes	Y N	Y N	Allergy	Y N	Y N
High Blood Pressure	Y N	Y N	Autoimmune Disorder	Y N	Y N
Skin Conditions	Y N	Y N	Shingles	Y N	Y N
Hepatitis (Type:)	Y N	Y N	Vascular Disease	Y N	Y N
Thyroid Disease	Y N	Y N	High Cholesterol	Y N	Y N

Are you pregnant? Y N If yes, how many weeks?_____

Other Medical History:_____

Current Medications/Vitamins/Supplements:_____

_____

_____

Allergies to Medications: _____

Social History Current Smoker Y N Alcohol Y N Recent Weight gain or loss Y N

Past Smoker Y N Drug Use: Y N If so, Type_____

Review of Systems: Please circle if you are currently experiencing:

Fever	Sinus Problems	Coughing	Headaches
Rash	Sore Throat	Abdominal Pain	Paralysis
Anxiety	Excess Fatigue	Vomiting	Depression
Numbness	Chest Pain	Swollen Lymph Nodes	Itching
Dizziness	Irregular Heartbeat	Abnormal Bleeding	Problems with skin
Hearing Loss	Short of Breath	Swelling of Joints	Problems w/muscles

Patients Name (Print) _____Date: _____

Doctors Signature: _____

Eye Care Plus, LLC

ACKNOWLEDGEMENT OF NOTIFICATION OF PRIVACY PRACTICES

By signing I acknowledge that I have been notified that there is a copy of the Notice of Privacy Practices available at the office of Eye Care Plus, LLC (ECP).

_____ _____

*PATIENT/GUARDIAN SIGNATURE DATE

_____

- (Print) PATIENT NAME

_____

If signed by personal representative, relationship to patient

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Authorization To Release Protected Health Information (PHI)

With your permission, we may disclose your PHI to the individuals identified below. I authorize Eye Care Plus, LLC to release any personal information relating to my health care.

To: _____ Relationship To Patient: _____

To: _____ Relationship To Patient:_____

To: _____ Relationship To Patient:_____

Office Use Only:
If written acknowledgement is not obtained, our practice must document its good faith efforts to obtain such acknowledgement and record the reason why the acknowledgement was not obtained.

Refused to Sign _____ Physically unable to sign _____
(Other) _____
Employee Signature: _____ Date : _____