LOWCOUNTRY
EYE CARE

Patient Information

Thank you for choosing our office. In order to serve you properly we need the following information. Please print.

Full Name (Mr./Mrs./Ms./Miss/Dr.) ____

Are you: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Minor (under 18 years old)

Parent's Name if Minor: ____

Address (and Mailing address if different) ____

City ______________________________________ State __________ ZIP __________

Home Phone ______________________________ Work Phone ____________________

Date of Birth ____________________ Age __________ Social Security Number _____ - _____- ______

Occupation ____________________ Hobbies/Special Interest ________________________

Email Address (Print Carefully) ____

Whom may we thank for referring you to our office?

Purpose of your visit today ____

Date of Last Eye Exam _______ Eye Doctor's Name ______________Age of Present Glasses ________

Do you wear Contact Lenses? Brand Are you interested in Contacts?

Personal/Family Doctor's Name ____

Insurance Information

Name of insured ____________________________ Relationship to patient________________

Birthdate ________________SS#/SIN ________________ Date employed ________________

Name of Employer ____

Address of Employer ____________________ City ______________ State __________ Zip __________

Insurance Company ____________________________ Group # ________________________

Personal and Family Health History

	Yourself	Your relatives that have had these problems
High Blood Pressure	Yes ☐ No ☐	______________________
Diabetes	Yes ☐ No ☐	______________________
Glaucoma (high eye pressure)	Yes ☐ No ☐	______________________
Cataracts	Yes ☐ No ☐	______________________
Macular degeneration	Yes ☐ No ☐	______________________

Do you have frequent headaches? Yes ☐ No ☐ How long have they occurred? ______________

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Have you had?

Any eye injuries	Yes ☐	No ☐	Crossed eye(s)	Yes ☐	No ☐
Any eye surgeries	Yes ☐	No ☐	Lazy eye	Yes ☐	No ☐
Eye infections	Yes ☐	No ☐	Double vision	Yes ☐	No ☐

What are the dates and details of the occurrences regarding the above?

Current Medication History

Please list below **all prescription and over the counter medications** you are now taking and what they are for. Please include any diet or birth control medications.
Check here ☐ if you **are not currently taking any medications.**

Do you have any drug or other allergies? Yes ☐ No ☐ If Yes, please list:

Review of Systems

Do you have problems with: (Please check all that apply - give details in the space to the right)

Skin	Yes ☐	No ☐	______________________
Ear, Nose, Throat and Mouth	Yes ☐	No ☐	______________________
Lungs / Breathing (TB)	Yes ☐	No ☐	______________________
Heart	Yes ☐	No ☐	______________________
Thyroid Disorders	Yes ☐	No ☐	______________________
Stomach / GI / Intestinal	Yes ☐	No ☐	______________________
Genitals / Kidneys / Bladder	Yes ☐	No ☐	______________________
Bones / Joints / Muscles	Yes ☐	No ☐	______________________
Psychiatric / Mental Concerns	Yes ☐	No ☐	______________________
Neurologic Systems	Yes ☐	No ☐	______________________
Lymphatic System	Yes ☐	No ☐	______________________
Blood or Bleeding Disorders	Yes ☐	No ☐	______________________

Social History: Do you?						
	Smoke	Yes ☐	No ☐	Drink Alcohol	Yes ☐	No ☐
	Chew Tobacco	Yes ☐	No ☐	Use drugs	Yes ☐	No ☐

Payment is due on the date services are rendered unless prior arrangements have been made.

Authorization & Release

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

Please sign ______________________________________ Date ______________________