MONINGER
EYE CARE

Patient Name _____ **DOB** _____ **Age** _____

Marital Status: Married Divorced Single Widow SSN _____ **Sex: M F**

Mailing Address _____**City** _____

Email_____ **State** _____ **Zip** _____

Cell Phone _____ **Daytime Phone**_____

Language Spoken_____ **Ethnicity:** Hispanic/Not Hispanic (circle one)

Emergency Contact_____ **Phone**_____

Primary Physician_____ **Phone**_____

Referred by_____ **Phone**_____

Describe the reason for your visit_____

Primary Insurance_____

Policy Holder_____ DOB _____ SSN _____

Secondary Insurance_____

Policy Holder_____ DOB_____ SSN_____

CoPay, Deductibles, and Coinsurance are due at the time of service

Consent to Treatment

I herby authorize the physicians and staff of Moninger Eye Care to perform procedures necessary to assess, diagnose, and treat my condition as necessary.

Authorization and Assignment of Benefits

I hereby authorize Moninger Eye Care to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign Moninger Eye Care all payments otherwise payable to me for services provided by Moninger Eye Care.
I understand that I am responsible for all charges incurred for my care.

Patient Signature_____ **Date**_____

Guarantor Name (Please Print)_____

Guarantor Signature_____ **Date**_____

Privacy

☐ **I authorize release of my medical information/testing to the person(s) I have listed below:**

_____ _____
(Name) (Relationship)

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PAST MEDICAL HISTORY:

Please Answer Each Question.
List any medical condition that you have had or currently have (i.e. diabetes, blood pressure, arthritis, etc.).

List any eye diseases that you have (i.e. glaucoma, cataract, retinal detachment, precious laser surgery).

List any surgeries that you have had by date and reason.

List any allergies to drugs or food.

List all medications that you are currently taking, including eye drops.

_____

_____

Pharmacy Name_____ **Phone Number**_____

FAMILY HISTORY:
List eye diseases that run in your family (i.e. glaucoma, macular degeneration)

SOCIAL HISTORY:
Do you now or have you smoked, consumed alcohol, abused drugs? How much and when? Does anyone live with you?

REVIEW OF SYSTEMS:
Do you currently have any other medical problems? Please circle Y (yes) or N (no) for each area. Explain any YES answers.

Y N Constitutional symptoms: Chronic fever, unexplained weight loss/gain, fatigue
Y N Ear/Nose/Throat problem
Y N Heart Problems
Y N Respiratory Problems
Y N Urinary problems
Y N Gastrointestinal Problems
Y N Hematological Problems
Y N Skin Problems
Y N Musculoskeletal Problems
Y N Neurological problems
Y N Psychiatric Problems