

## EYE ASSOCIATES – PATIENT INFORMATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Last) (First) (Middle)

Sex: Male \_\_\_\_\_ Female \_\_\_\_\_ Marital Status: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security # : \_\_\_\_\_ Home # : \_\_\_\_\_ Cell # : \_\_\_\_\_

Occupation: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_ Work # : \_\_\_\_\_

Spouse or Parent's Name: \_\_\_\_\_ Spouse or Parent's Work # : \_\_\_\_\_  
 (It is our policy that the parent who requests treatment for a child is responsible for all fees for services rendered)

Physician (Group): \_\_\_\_\_ Phone # : \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Location: \_\_\_\_\_ Phone # : \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone # : \_\_\_\_\_

Referred By (circle): Physician / Yellow Pages / Insurance Plan / Our Sign / Patient / Kremer Laser Center / Other

### Insurance Information:

	VISION	MEDICAL / HEALTH	SECONDARY MEDICAL <small>(list only if Medicare is primary)</small>
Carrier			
ID Number			
Group Number			
Insured's Name			
Patient's Relationship to Insured			
Insured's Birth Date			

(We only file for primary insurance – we will furnish you with a paid in full receipt for you to submit to secondary)

Who is responsible for this bill? \_\_\_\_\_ Relationship: \_\_\_\_\_ Home # : \_\_\_\_\_ Work # : \_\_\_\_\_

I will be paying today by: Cash \_\_\_\_\_ Check \_\_\_\_\_ Credit Card \_\_\_\_\_  
 (If filing insurance this pertains to co-pay and overages)

\*\*\*\*\* ALL PAYMENTS ARE DUE AT TIME SERVICES RENDERED \*\*\*\*\*

I authorize the release of any medical information necessary to process an insurance claim, if applicable. I request payment of authorized benefits to be paid to Eye Associates for any services furnished to me by the physician or supplier. I authorize the doctor or staff to complain on my behalf to the Insurance Commissioner. I understand that I am financially responsible for payment on any services or supplies that are deemed medically necessary or non-covered services regardless of my insurance status, including refractions, contact lens evaluations, materials or supplies. It is my responsibility to notify this office prior to scheduling of any changes in my insurance plan. I further understand that I am responsible for charges incurred when insurance coverage has denied claims for any reason or terminated my policy. I authorize release to my insurance company any information required to process my claim. I understand that if for any reason there is a balance left on my account there will be a financial charge of 1.5% per month added to my account that is compounded monthly. If my account is not paid in full I understand my account will be forwarded to a collection agency with a Twenty Five Dollar collection fee to be paid by me. I have read all information on this sheet and have completed the information to the best of my knowledge, I certify this information is true and correct.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent/Guardian if patient is under 18)

**This list of symptoms of visual perceptual problems occurring at school, work, and home will help us to understand how you perform visually in daily activity.**

**Please circle one of the following for each of the questions:  
O - often S - sometimes N - never**

### **READING, WRITING AND OTHER DESK TASKS**

- |   |   |   |   |
|---|---|---|---|
| Fatigue with reading or comprehension drops with time           | O | S | N |
| Confusion of similar words or letters                           | O | S | N |
| Short attention span  | O | S | N |
| Difficulty keeping place while reading (using finger as marker) | O | S | N |
| Slow reading or word-by-word reading                            | O | S | N |
| Skips or re-reads lines or omits words                          | O | S | N |
| Avoidance of reading or close work                              | O | S | N |
| Reverses words or letters                                       | O | S | N |
| Difficulty remembering what has been read                       | O | S | N |
| Tilts head to one side or closes or covers one eye              | O | S | N |
| Holds head too close to the material when reading or writing    | O | S | N |
| Difficulty copying from chalkboard or book                      | O | S | N |
| Poor eye hand coordination, including writing                   | O | S | N |
| Awkward pencil grip, posture or body position                   | O | S | N |

### **BODY POSTURE AND SPACE AWARENESS**

- |   |   |   |   |
|---|---|---|---|
| Unusual awkwardness, frequent tripping or stumbling | O | S | N |
| Confusion of right and left directions              | O | S | N |

### **GENERAL BEHAVIOR AND OBSERVATIONS**

- |  |   |   |   |
|--|---|---|---|
| Crossed eyes, turning in or out                            | O | S | N |
| Watering or blood shot eyes                                | O | S | N |
| Dislike for tasks requiring sustained visual concentration | O | S | N |
| Nervousness, irritability or restlessness after reading    | O | S | N |
| Frequent signs of frustration                              | O | S | N |
| Tension during close work                                  | O | S | N |

### **GENERAL QUESTIONS**

- |  |   |   |   |
|--|---|---|---|
| Does your vision get blurry at any time?   | O | S | N |
| Do objects or lines of print double?   | O | S | N |
| Do you have headaches, dizziness or feel sick to your stomach when you use your eyes or do you get car sick? | O | S | N |
| Do letters and lines "run together" or words "jump"?   | O | S | N |
| Do you have difficulty coordinating eyes and hands in sports?  | O | S | N |
| Do your eyes feel strained, tired or sore after doing near work or when on the computer?                     | O | S | N |