Geneva Eye Care Inc
Welcome To Our Office

Welcome to Geneva Eye Care Inc. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name _____ MI _____ Last Name _____ Preferred Name _____

Street Address _____ City _____ State Zip _____

Social Security Number _____ Home Phone - Include Area Code _____ Day Phone _____ Phone Type _____

Date of Birth _____ Guardian (if under 18) _____ Email Address _____

Emergency Contact _____ Relationship _____ Emergency Phone _____

How were you referred to our office?

☐ Phone Book ☐ School ☐ Advertisement ☐ Patient
☐ Insurance Listing ☐ Drive by ☐ Other ☐ Doctor

Who were you referred by? _____

Race

☐ American Indian Or Alaska Native ☐ Native Hawaiian Or Other Pacific Islande
☐ Asian ☐ White
☐ Black Or African America ☐ Declined To Specify
☐ Hispanic Or Latino

Other Race _____

Ethnicity ○ Hispanic Or Latino ○ Not Hispanic Or Latino ○ Filipino ○ Declined To S

Preferred Language ○ English ○ Spanish ○ Mandarin ○ Cantonese ○ Dutch; Flemish

Height ft _____ in _____ cm/m _____ ◉ ft in ○ cm ○ m **Weight** _____ ◉ lbs ○ kg

Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient.The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to . I understand that will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

I Authorise the release of information to all my insurance companies and my doctor to act as my agent in helping me obtain payment direct to my doctor.

Signature _____ Date _____

PRIMARY CARE PHYSICIAN

Primary Care Physician and Clinic Name

Address of Primary Care Physician City State Zip Phone

REFERRING PHYSICIAN

Referring Physician and Clinic Name

Address of Referring Physician City State Zip Phone

HEALTH HISTORY

What is the main reason for today's exam ? _____ When was your last exam ? _____

When was your last health exam ? _____

Past Illnesses or Injuries: _____ _____

Past Surgeries: _____ _____

Current Medications: _____ _____

_____ _____

Current Eye Drops: _____ _____

_____ _____

Medicines that cause reactions or sensitivities: _____

Specific Allergies: _____

EYE HISTORY

Glaucoma	○ Yes	○ No	Dryness	○ Yes	○ No	Strabismus (Crossed Eyes)	○ Yes	○ No
Cataract	○ Yes	○ No	Excess Tearing/Watering	○ Yes	○ No	Blurred Vision Distance	○ Yes	○ No
Macular Degeneration	○ Yes	○ No	Eye Pain or Soreness	○ Yes	○ No	Blurred Vision Near	○ Yes	○ No
Retinal Detachment	○ Yes	○ No	Foreign Body Sensation	○ Yes	○ No	Distorted Vision (halos)	○ Yes	○ No
Color Blindness	○ Yes	○ No	Infection of Eye or Lid	○ Yes	○ No	Double Vision	○ Yes	○ No
Headaches	○ Yes	○ No	Itching	○ Yes	○ No	Floaters or Spots	○ Yes	○ No
Glare/Light Sensitivity	○ Yes	○ No	Mucous Discharge	○ Yes	○ No	Fluctuating Vision	○ Yes	○ No
Tired Eyes	○ Yes	○ No	Drooping Eyelid	○ Yes	○ No	Loss of Vision	○ Yes	○ No
Amblyopia (Lazy Eye)	○ Yes	○ No	Redness	○ Yes	○ No	Loss of Side Vision	○ Yes	○ No
Burning	○ Yes	○ No	Sandy or Gritty Feeling	○ Yes	○ No			

GENERAL HEALTH CONDITION

Fever	○ Yes	○ No	Respiratory (Asthma)	○ Yes	○ No	Anxiety or Depression	○ Yes	○ No
Weight Loss	○ Yes	○ No	Gastrointestinal	○ Yes	○ No	Thyroid, Diabetes	○ Yes	○ No
Other Symptoms	○ Yes	○ No	Kidney	○ Yes	○ No	Blood/Lymph	○ Yes	○ No
Ears, Nose, Throat	○ Yes	○ No	Muscles, Bones, Joints	○ Yes	○ No	Allergic	○ Yes	○ No
Cardiovascular (high blood pressure etc.)	○ Yes	○ No	Skin	○ Yes	○ No	**Pregnant**	○ Yes	○ No
			Neurological (Multiple Sclerosis)	○ Yes	○ No	**Nursing**	○ Yes	○ No

FAMILY HISTORY

Amblyopia (Lazy Eye)	○ Yes	○ No	Retinal Detachment	○ Yes	○ No	High Blood Pressure	○ Yes	○ No
Blindness	○ Yes	○ No	Strabismus (Eye Turn)	○ Yes	○ No	Kidney Disease	○ Yes	○ No
Cataract(s)	○ Yes	○ No	Arthritis	○ Yes	○ No	Lupus	○ Yes	○ No
Color Blindness	○ Yes	○ No	Cancer	○ Yes	○ No	Stroke	○ Yes	○ No
Glaucoma	○ Yes	○ No	Diabetes	○ Yes	○ No	Thyroid Disease	○ Yes	○ No
Macular Degeneration	○ Yes	○ No	Heart Disease	○ Yes	○ No	Others	○ Yes	○ No