



Welcome and thank you for choosing Little Elm Eye Care for your vision needs. We are here to serve you, so please let us know if there is anything we can do to make your visit more enjoyable.

**Personal Information**

Name: Last, First, Middle \_\_\_\_\_ Preferred Name: \_\_\_\_\_

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

Phone: Home \_\_\_\_\_ Work: \_\_\_\_\_ Cell/Alt. # \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Driver's Lic. # & State: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Race: Amer. Indian or Alaskan Native, Asian, African-American, Native Hawaiian or Pacific Islander, White, Other, Decline to answer (Circle)

Ethnicity: Not Hispanic or Latino, Hispanic or Latino, Unknown, Decline to answer (Circle) Primary Language: \_\_\_\_\_

What are your hobbies? \_\_\_\_\_ E-mail Addr.: \_\_\_\_\_

Any Children? What ages? \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

**Account Responsible Information**

Name of Responsible Party (Self, Spouse, Parent): \_\_\_\_\_

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

Phone: Home \_\_\_\_\_ Work: \_\_\_\_\_ Cell/Alt. # \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Driver's Lic. # & State: \_\_\_\_\_

**Insurance Information**

Primary Insured Name: \_\_\_\_\_ Primary Insured Social Security #: \_\_\_\_\_

Primary Insured Date of Birth: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

Please bring a copy of your medical insurance card to your appointment.

When was your last eye exam? \_\_\_\_\_ Where was it? \_\_\_\_\_

Do you wear glasses? \_\_\_\_\_ Contact Lenses? \_\_\_\_\_ If no, have you ever worn Contact Lenses? \_\_\_\_\_

**Financial Responsibility**

I am aware that professional fees and contact lens fitting fees are due at the time of service. I understand that Little Elm Eye Care will attempt to verify my insurance coverage, but if my insurance fails to reimburse despite the efforts, I will be responsible for paying the bills in full. I understand that I am responsible for knowing what my insurance benefits are. I authorize payment of medical/vision benefits to the provider of service.

Initial \_\_\_\_\_

**Office Policy**

Little Elm Eye Care reserves the right to charge patients who fail to cancel their appointments within 24 hours notice. Please note that appointments are reserved for you, and we will make every effort to accommodate your requests for an appointment.

Initial \_\_\_\_\_

There is a \$30 fee for all returned checks. Glasses orders are personalized for your prescription. Little Elm Eye Care will do everything possible to ensure that you are happy with your glasses; however, if you choose to return your glasses, there is a 40% restocking fee.

Initial \_\_\_\_\_

**HIPAA Privacy Practices**

I acknowledge that I received a copy of Little Elm Eye Care's Notice of Privacy Practices.

Initial \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient/Guardian

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Personal Medical & Ocular History**—Please check any of the following conditions you have or have had.

***Ear, Nose, Mouth, and Throat***

- Hearing Loss
- Sinusitis
- Seasonal Allergies

***Cardiovascular***

- High Blood Pressure
- High Cholesterol
- Heart Disease/Heart Attack

***Respiratory***

- Asthma
- Pneumonia
- Shortness of Breath

***Gastrointestinal***

- Acid Reflux
- Colitis/Crohn's Disease

***Genitourinary***

- Kidney disease
- Kidney stones
- Ovarian cysts

***Musculoskeletal***

- Arthritis
- Back Pain
- Gout

***Skin***

- Eczema
- Rosacea
- Skin cancer

***Neurological***

- Epilepsy/Seizures
- Multiple sclerosis
- Migraines
- Headaches
- Stroke

***Psychiatric***

- Depression
- Anxiety
- Dementia

***Endocrine***

- Diabetes
- Thyroid Disease

***Hematologic/Lymphatic***

- Anemia
- Leukemia

***Infectious Disease***

- HIV
- Tuberculosis

***Ocular History***

- Glaucoma
- Cataracts
- Macular Degeneration
- Retinal Disease
- Blindness
- Strabismus/Lazy Eye
- Eye Injury
- Dry Eye

Please list all medical problems that were not addressed above: \_\_\_\_\_

Please list all medications you are taking (incl. eye medications): \_\_\_\_\_

Please list all drug allergies and sensitivities: \_\_\_\_\_

Please list any past major illnesses or surgeries: \_\_\_\_\_

**Family History**—Does anyone in your family suffer from the following conditions:

- Glaucoma
- Cataracts
- Macular degeneration
- Retinal Disease
- Strabismus/Lazy eye
- Blindness
- Diabetes
- High Blood Pressure
- Heart Disease