WELCOME TO 3 GUYS EYECARE CENTER

Thank you for choosing 3 Guys Eyecare Center. In order for us to maximize your vision benefits, please fill out this form as completely

Patient Demographic Information

Last Name	First Name	Middle Initial	Date of Birth	Age	Social Security Number

Street Address	Apartment	City	State	Zip Code

Home Phone Number	Mobile Phone Number	Work Phone Number	Email Address

Gender	Employer	Occupation

If Patient is a Minor (for financial purposes)

Parent or Guardian Full Name	Relationship to Patient	Parent/Guardian Date of Birth	Parent/Guardian SSN (optional)

Parent/Guardian Street Address	Apartment	City	State	Zip Code

Parent/Guardian Phone Number	Parent/Guardian Employer	Parent/Guardian Occupation

Primary Vision Insurance

Name of Insurance	
Policy Holder Name	
Policy Number	Group Number

Secondary Vision Insurance

Name of Insurance	
Policy Holder Name	
Policy Number	Group Number

Primary Medical Insurance

Name of Insurance	
Policy Holder Name	
Policy Number	Group Number

Secondary Medical Insurance

Name of Insurance	
Policy Holder Name	
Policy Number	Group Number

Policy Holder Information

Policy Holder Full Name	Relationship to Patient	Policy Holder Date of Birth	Policy Holder SSN (optional)

Parent/Guardian Street Address	Apartment	City	State	Zip Code

Parent/Guardian Phone Number	Parent/Guardian Employer	Parent/Guardian Occupation

Statement of Financial Responsibility

In order for 3 Guys Eyecare to service my account, or to collect any amounts I may owe, I agree I may be contacted at any number or address I have provided. I furthermore agree to pay any collection expenses incurred to collect any amount I may owe. I understand that I am solely responsible for the cost of all non covered items, as outlined in detail on my receipt, which includes the specific date of service, description of each procedure/service, and the amount I am responsible for paying out of pocket. I certify that I have been informed of all items and cost. Our office will file all vision claims if we are a participating provider for your plan. However, if your insurance denies payment for any claims submitted, you will be responsible for full payment. Otherwise we will supply you with an itemized statement which you may submit to your insurance carrier.

Patient Printed Name	Patient Signature	Today's Date

Continue on reverse side

Patient Medical Information

Many medical conditions and medications affect the eyes. Please help the doctor by filling out your medical history as completely as possible. Please check all of the conditions that apply to you.

☐ Yes ☐ No Have you had any eye injuries, eye surgeries, eye diseases, floater or flashes of light? Explain below:

☐ Yes ☐ No Breathing Problems
○ Asthma ○ Emphysema

☐ Yes ☐ No Skin Condition
○ Eczema ○Rosacea

☐ Yes ☐ No Endocrine Disorder
○ Diabetes ○ Thyroid Disorder

☐ Yes ☐ No Stomach Problem
○ Heartburn

☐ Yes ☐ No Heart Problem
○ High Blood Pressure ○ Heart Failure

☐ Yes ☐ No Blood Disorder
○ Sickle Cell ○ High Cholesterol

☐ Yes ☐ No Allergy/Immunology
○ Hay Fever ○ HIV ○ Lupus

☐ Yes ☐ No Kidney/Bladder Problem

☐ Yes ☐ No Surgical Operations

☐ Yes ☐ No Fever/Fatigue/Weight Loss

☐ Yes ☐ No Cancer

☐ Yes ☐ No Musculoskeletal Conditions
○ Arthritis ○ Osteoporosis

☐ Yes ☐ No Ear/Nose/Throat Problems
○ Sinus Problems ○Dental Problems

☐ Yes ☐ No Neurological Disorder
○ Migraines ○ Multiple Sclerosis
○ Stroke ○ Myasthenia Gravis
○ Head Injury

☐ Yes ☐ No Sexually Transmitted Diseases

☐ Yes ☐ No Other Autoimmune Disease
If yes, what:

☐ Yes ☐ No Are you currently being treated for any other medical conditions?
If yes, what:

☐ Yes ☐ No Psychiatric Disorder

Date of last health exam: Date of last eye exam: Previous eyecare provider:

Please list any medications you are currently taking:

Are you allergic to any medications? ☐ Yes ☐ No If yes, please list:

Are you currently nursing or pregnant? ☐ Yes ☐ No

Is there any possibility that you might be pregnant? ☐ Yes ☐ No

Do you smoke or use tobacco? ☐ Yes ☐ No ○ Less than 1 Pack a Day ○ 1-2 Packs a Day ○ 2 Packs a Day

Do you drink alcohol? ☐ Yes ☐ No ○ Social ○ 1-2 Drinks Daily ○ Above Average Use ○ Dependence

Has anyone in your family had (please list their relationship to you):

☐ Yes ☐ No Diabetes:
☐ Yes ☐ No High Blood Pressure:
☐ Yes ☐ No Heart Disease:
☐ Yes ☐ No Respiratory Disease:
☐ Yes ☐ No Cataract:
☐ Yes ☐ No Glaucoma:
☐ Yes ☐ No Macular Degeneration:
☐ Yes ☐ No Blindness:
☐ Yes ☐ No Cancer:
☐ Yes ☐ No Other Eye Disease:

Do you currently wear contact lenses? ☐ Yes ☐ No

If yes, what brand? How many hours do you wear your lenses each day? ☐ < 4 ☐ 4-8 ☐ 8-12 ☐ 12 +

How often do you throw away your lenses? ☐ Daily ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Yearly

Notice of Information Practices and Privacy Statement

The HIPAA Policy was available to read during my office visit ☐ Yes ☐ No

Patient Printed Name	Patient Signature	Today's Date

Optional Service: Optical Photography

Initial

Although IOP readings and visual fields are helpful, clinicians cannot use them alone to accurately predict which patients have glaucoma or which patients' disease is progressing. Optic disc stereo photography has traditionally been the gold standard for the documentation of the optic nerve head's appearance. The optical photography is $35.00.

Optional Service: Visual Field Test

Initial

A routine exam may not detect diseases early enough to prevent permanent vision loss. A visual field test evaluates your peripheral vision and may alert us to the presence of potential vision-threatening diseases such as Glaucoma, tumors, neurological diseases, and retinal detachment. This test can also detect certain systematic diseases such as hypertension, lupus, and diabetes, all of which can also lead to vision loss. The visual field test is $ 20.00

Office Use Only: Entrance Prescription

Eyeglass Prescription

Contact Lens Prescription