BUCKINGHAM EYE ASSOCIATES, P.C.

Welcome to our office! Thank you for choosing our office for your eye care. Please take the time to complete this form accurately and completely. It helps us do the best job possible for you. This information is held in complete confidence as it is part of your permanent record, and will not be released to anyone unless you authorize its release in writing.

Preferred Salutation

Dr. Mr. Mrs. Ms. Miss Reverend Other:____________________

Last	First	Middle Initial	Birth Date	Marital Status
Address		City	State	Zip Code
Residence Phone		Social Security #	If Minor, Parent Name	
Employer		Occupation	Business Phone	
Spouse Name		Date of Birth	Social Security #	
Employer		Occupation	Business Phone	

EMail ____________________

INSURANCE INFORMATION

We require all insurance information prior to services being provided. Due to the diverse nature of many eye conditions, disorders, and procedures, many of the services we provide are covered by your MAJOR MEDICAL INSURANCE rather than routine vision coverage. Please provide us with the following information even if you believe that you are seeing us for a non-medical reason.

MEDICAL INSURANCE COMPANY	Policy #	Group #	Subscriber Name
SECONDARY INSURANCE CO.	Policy #	Group#	Subscriber Name

REFERRAL INFORMATION

How did you learn about our office. (Please circle the appropriate sources that apply)

Relative Friend Yellow Pages Doctor Referral HMO - Insurance Location Newspaper Other

List family members (relationship) who are patients in this office ____________________

If you are a new patient, who may we thank for referring you to this office? ____________________

Please provide us with the name and telephone number of your Primary Care Physician ____________________

I authorize the release of any medical or other information necessary to process any claims arising from services and materials provided. I also request payment of government or private insurance benefits to the physician accepting assignment for service and materials provided. I also understand that I assume all financial responsibility for this account for any amounts due, regardless of insurance coverage.

Signature Date Relationship to Patient

PATIENT HEALTH HISTORY

Patient Name________________________ DOB ___/_____/______ Gender M F

Email____ Occupation_____________________________

Primary Care Physician__________________ Date Last Seen ___________

Medical (Family History (Use back of Sheet if you need more space)

Please List all your current medications (include over the counter vitamins and herbal therapy)____

List all major surgeries(Eye surgery included)

List any allergic reactions to medications or eye drops

Please indicate if any of the conditions apply to you or a family member (blood relatives only)

Disease/ Condition	Yourself
Cataract	Yes No
Eye Turn	
Glaucoma	
Macular Degeneration	
Retinal Detachment	

Women: Are you pregnant Yes No
Are you breast feeding Yes No

Disease/ Condition	Family Member Yes No	Relationship (Blood Relatives Only)
Blindness		____________________
Eye Turn		____________________
Glaucoma		____________________
Macular Degeneration		____________________
Retinal Detachment		____________________
Other		____________________

Review of Systems Please indicate below if you have or ever have had problems with the following conditions:

Allergic/Immunologic	Ear Nose and Throat	Gastrointestinal	Skin/Integumentary	Psychiatric
None	None	None	None	None
Lupus	Sinusitis	Crohn's Disease	Eczema	Depression
Rheumatoid Arthritis	Upper Respiratory	Colitis	Rosacea	Bi-Polar
Environmental Allergies	Tract Infection	Acid Reflux/Ulcer	Psoriasis	Schzophrphrenia
Seasonal Allergies	Other	Other	Other	Other
Other (I.e,Latex)				

Cardiovascular	Endocrine/Glands	Respiratory	Muscle/Skeletal	Genital/Urinary
None	None	None	None	None
High Blood Pressure	Diabetes	Asthma	Arthritis	HIV Positive
Heart Disease	Hormone Dysfunction	Bronchitis	Fibromyalgia	Herpes/Chlamydia
Stroke	Thyroid Dysfunction	Emphysema	Ankylosing Spondylitis	Other
Vascular Disease	Other	Other	Other	
High Blood Cholesterol				

Hematologic	Neurological	General Health
None	None	None
Anemia	Multiple Sclerosis	Weight/Loss/Gain
Leukemia	Epilepsy	Fever
Bleeding Disorder	Tremors	Fatigue
Other	Other	Trauma

Social
Non Smoker? Yes _____ No_____________
Former Smoker? Yes______ No____________
When Quit?_________________________
Current Smoker? How often?______________
Non-Prescription Drugs_________________
Alcohol Consumption Yes/No
How often?___________________________
Height______________ Weight_____________

Please sign below to acknowledge that this form is accurate.

Signature_____________________________________ Date____________________

Acknowledgement of Receipt of Notice of Privacy Practices

My signature verifies that I have received a copy of the Notice of Privacy Practices

Name of Patient (Print)_______________________ Signature___________________________ Date____________

Signature of Patient Representative (if minor or an adult unable to sign this form)__________________________

Relationship of Patient Representative to Patient____