The EyeCare Center
1225 West Northland Avenue
Appleton, WI 54914
920-731-2020

□ Mr. □ Mrs.□ Ms.□ Dr.□ Other Today's date ____/____/____

First Name_____ MI____Last Name_____

Date of Birth ____/____/____ Preferred Name _____

Address_____

City_____State_____ Zip code_____

Home phone_____ □ Cell phone_____

Work phone_____ □ Email address _____

Occupation _____ Place of Employment _____

Family members' names and ages _____
_____

If we are submitting claims to insurance on your behalf, you MUST fill in the following information:

Insurance Company_____

Name of Primary card holder_____Cardholder's date of birth_____

Relationship to patient □ Self □ Spouse □Father □ Mother □ Other_____

How did you hear about our office?
□ Friend or family referral_____□ Insurance □ Sign □ Website □ Google □ Facebook □ □Yellow pages

Government required questions
Preferred Language □ English □ Spanish □ Hmong □ French □ German □ Other _____
Race □Caucasian □ African American □ Hispanic or Latino □ Asian □ Native American
Ethnicity □ Hispanic or Latino □ Not Hispanic or Latino □ Native Hawaiian or other Pacific Islander
Communication Preference □ Telephone □E-Mail □ Postal

Authorization

I have read and understand the above information. I have provided accurate information to the best of my knowledge. I request that payment of authorized insurance benefits be made on my behalf to Jorgensen, Schulz and Assoc. EyeCare Center, S.C. I also authorize the release of any information necessary to process claims. I permit my signature to be kept on file for future claims. **Any services not covered by insurance are my responsibility.**

Signature _____ Date _____

Parent signature if child _____

Over please →

Reason for today's visit _____

Last eye exam_____Doctor _____

Do you have questions about laser refractive surgery? □ Yes □ No
Do you have questions about other eye issues? □ Yes □ No

If yes, please explain: _____

Past History
Have you been diagnosed with eye problems: Cataract Y / N Glaucoma Y / N Macular degeneration Y / N
Other: _____
Have you ever had any surgeries, including eye surgeries? _____

Family History
Has anyone in your family been diagnosed with: Cataract Y / N Glaucoma Y / N Macular degeneration Y / N
Has anyone in your family ever been treated for: Hypertension Y / N Diabetes Y / N Eye problems Y / N

Social History
Does your occupation require special use of your eyes? If yes, please explain _____
_____

Review of Systems (Please check neg. if no problems in each category)

Allergic/immunologic Neg _____
□ Drug allergy _____
□ Environmental allergy___
□ Rheumatoid arthritis___
□ Lupus___
□ Sjogren's disease___

Psychiatric Neg____
□ Depression___
□ Panic disorder___ □

Cardiovascular Neg ___
□ Heart disease___
□ High blood pressure/hypertension___
□ Stroke___ □
□ Vascular disease___
□ High cholesterol___

Eyes Neg ___
□ Glaucoma___
□ Cataract___
□ Macular degeneration ___
□ other _____

Endrocrine Neg. ____
□ Non-insulin dependant diabetes___
□ Insulin dependant diabetes___
□ Thyroid dysfunction___
□ Hormonal dysfunction___ □

Integumentary Neg ___
Eczema___
□ Rosacea___
□ Psoriasis___

Gastrointestinal Neg ___
Crohn's___
□ Colitis___ □
□ Ulcer___
□ Digestive issues___

Neurological Neg ___
□ Multiple sclerosis___
□ Epilepsy___
□ Alzheimer's___

Hematologic/Lymphatic Neg ____
□Anemia___
□Leukemia___
□Large volume blood loss___

Respiratory Neg ___
Cigarette smoker___
□ Asthma___
□ Bronchitis___
□ Emphysema___

Musculoskeletal Neg ___
□ Fibromyalgia___
□ Muscular dystrophy___
□ Osteoarthritis___
Ankylosing spondylitis___

Genitourinary Neg ___
□ STD___
□ Prostate Cancer___

Ear, Nose. Mouth & Throat Neg___
□ Upper respiratory tract infection___

Other conditions not listed above:_____

Drug allergies _____

Medications including prescription, eye drops, vitamins or over the counter _____
_____

Primary Care Physician _____