

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 _____

Endocrine 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 _____