WISDA EYE CENTER, PC
PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Current Age:_____ SS #:_____ Phone: _____

Phone Number Where You Can Be Reached To Confirm Appointment: _____

If Minor, Guarantor name: _____ ☐ Child/Guarantor Has Same Address

Address of Patient (or minor): _____

City: _____ State:_____ Zip: _____

Address of Guarantor: _____

City:_____ State: _____ Zip: _____ Phone #: _____

Gender: _____ Marital Status: _____

Family (or Referring) Physician: _____

Physician's Address: _____ Physician's Phone:_____

INSURANCE INFORMATION (Please present ALL insurance cards for copying)

PRIMARY INSURANCE: _____ Policy #: _____ Group: _____

Subscriber: _____ Relationship: _____ Date of Birth: _____

SS #: _____ Employer: _____ Phone: _____

Address: _____

Name of Vision Plan (if applicable): _____

SECONDARY INSURANCE INFORMATION (Please present ALL insurance cards for copying)

INSURANCE: _____ Policy #: _____ Group: _____

Subscriber: _____ Relationship: _____ Date of Birth: _____

SS #: _____ Employer: _____ Phone: _____

Address: _____

In Case of an Emergency:
Closest relative not living with you: _____

Relationship: _____ Phone: _____

Office Policy for Patients with Insurance Coverage

In order to accommodate the needs and requests of our patients, we have enrolled in many insurance companies.

We are pleased to be able to provide this service to you, but it is not possible for us to keep track of all the individual policies, changes, and updates of all the plans. Each has different requirement's regarding how often services may be rendered, and even more importantly, where those services may be performed. It is imperative that you, as the patient, know your policy.

Within the same insurance company the plans differ depending upon what type of contract your employer has negotiated.

Providing quality medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance contract guidelines if, you let use know at each time of service, exactly what are those guidelines.

Unfortunately, if you do not inform us of any special requirements in your contract and we subsequently order services (such as testing, lab work) that are not covered, our office or the selected medical facility will have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility.

If your insurance charges or is not active for services to be billed and we are not clearly notified and documented, you will be responsible for all fees that have been incurred. If your insurance company violates its contract with office, you will be responsible for all financial balances.

In the event we don't participate with your insurance company and we are able to bill them partial payment, you will be responsible for any balances left unpaid by your insurance.

I have read and understand the office policy and aggress to accept responsibility as requested above. I authorize direct payment to **Wisda Eye Center**.

I HAVE RECEIVED AND/OR READ THE "NOTICE OF PRIVACY PRACTICES" PROVIDED TO ME BY WISDA EYE CENTER.

I AGREE TO AND UNDERSTA ALL CONTENTS ON THIS FORM BOTH ON THE FRONT PAGE AND BACK. THE SIGNATURE BELOW IS FOR ALL ITEMS WITHIN.

I hereby authorize **WISDA EYE CENTER** to bill my Insurance, which may include release of Medical Information to process the claim. I also authorize payment to be made directly to **WISDA EYE CENTER**.

SIGNATURE _____ **DATE** _____

WISDA EYE CENTER – Patient Questionnaire

Name: _____

Date: _____

Do you have problems in the following areas? (please check all that apply)

- ❑ Fever
- ❑ Weight Loss
- ❑ Ear Problems
- ❑ Sinus Infections
- ❑ Seasonal Allergies
- ❑ Cough
- ❑ Chest Pain/Angina
- ❑ Previous Heart Attack
- ❑ Irregular Heart Beat
- ❑ High Blood Pressure
- ❑ Shortness of Breath
- ❑ Asthma
- ❑ Emphysema
- ❑ Stomach Ulcers
- ❑ Chronic Diarrhea
- ❑ Kidney Problems
- ❑ Urination Problems
- ❑ Arthritis/Joint Pain
- ❑ Skin Problems
- ❑ Seizures
- ❑ Headaches
- ❑ Depression
- ❑ Anxiety
- ❑ Psychiatric Problems
- ❑ Diabetes
- ❑ Thyroid Problems
- ❑ Anemia
- ❑ Excessive Bleeding
- ❑ Cancer
- ❑ Presently Pregnant?
- ❑ Previous Surgery

- ❑ Blurred Vision
- ❑ Double Vision
- ❑ Sudden Loss of Vision
- ❑ Redness of Eyes
- ❑ Itching/Burning Eyes
- ❑ Excessive Tearing
- ❑ Light Sensitivity/Glare
- ❑ Eye Pain/Soreness
- ❑ Sandy/Gritty Feeling in Eyes
- ❑ Poor Reading Vision
- ❑ Poor Distance Vision
- ❑ Difficulty Driving
- ❑ Poor Night Vision
- ❑ Childhood Lazy Eye
- ❑ Crossed Eyes
- ❑ Drooping Eyelids
- ❑ Previous Eye Surgery
- ❑ Wear Glasses?
  How Old is this Pair?
  _____
- ❑ Wear Contact Lenses?
  Gas Permeable Soft Disposable
  How Old is this Pair?
  _____
- ❑ Would you like to try Contact Lenses?
- ❑ Past Eye Injuries
- ❑ Diabetic Retinopathy
- ❑ Macular Degeneration
- ❑ Glaucoma
- ❑ Cataract

❑ Please list any medication you are currently taking:

_____

_____

_____

_____

_____

_____

_____

_____

❑ Do you have allergies to medication? If so, please list:

_____

_____

BOTOX

- ❑ Are you frequently exposed to the Sun's rays?
- ❑ Do you currently have problems with wrinkles or any uneven skin tone?
- ❑ Would you be interested in an anti-aging cream treatment?
- ❑ Would you be interested in Botox injections?

Name of Surgery _____ Year _____

Family History

Please ✓ if any blood relatives have had the following problems and list Relationship to Patient

- ❑ Cataract _____ Cancer/Tumor _____
- ❑ Glaucoma _____ Heart Attack _____
- ❑ Diabetes _____ Macular Degeneration _____
- ❑ Stroke _____ Retinal Detachment _____

Social History

Occupation _____

- ❑ Do you Drink Alcohol? ____ Drinks per week
- ❑ Do you Smoke? ____ Packs per Day
- ❑ Do you Exercise Regularly? ❑ Yes ❑ No
- ❑ Do you Take Vitamins? ❑ Yes ❑ No

Physician Reviewed: _____