Cox EYECARE

WELCOME TO OUR OFFICE!

(IN OFFICE USE ONLY)
SCANNED: ☐
ESCRIPT: ☐

PLEASE PRESENT ALL VISION AND MEDICAL INSURANCE INFORMATION TO RECEPTIONIST

PAYMENT IS DUE WHEN SERVICES ARE RENDERED AND/OR MATERIALS ARE ORDERED

MR. ☐ MRS. ☐ MS. ☐ DR. ☐ BIRTH DATE: ____/____/____

FULL NAME: _____ PREFERRED NAME: _____

ADDRESS: _____ SSN#: ____/____/____

CITY/STATE/ZIP: _____ CELL PHONE: _____

EMAIL ADDRESS: _____ HOME PHONE: _____
(NOTE: AN EMAIL ADDRESS IS REQUIRED IN ORDER FOR YOU TO GAIN ACCESS TO OUR OFFICE'S PATIENT PORTAL)

EMPLOYER/OCCUPATION: _____ WORK PHONE: _____

RACE/ETHNICITY: AMERICAN INDIAN/ALASKA NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ HISPANIC OR LATINO ☐
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ WHITE OR CAUCASIAN ☐ PREFER NOT TO ANSWER ☐ OTHER ☐

PREFERRED METHOD OF CONTACT (CHOOSE ALL THAT APPLY): TEXT ☐ CALL ☐ EMAIL ☐

MARITAL STATUS: SINGLE ☐ MARRIED ☐ DIVORCED ☐ OTHER ☐

RESPONSIBLE PARTY (IF UNDER 18): _____ PHONE NUMBER: _____

RELATIONSHIP TO PATIENT: _____ REFERRED BY: _____

PRIMARY CARE PROVIDER/CLINIC: _____

PREFERRED PHARMACY: _____

CHECK ALL THAT APPLY: TOBACCO USE: (HEAVY/FREQUENT) ☐ (LIGHT/OCCASIONAL) ☐ (FORMER) ☐ (NEVER) ☐ DRUG USE: ☐

ALCOHOL USE: (HEAVY/FREQUENT) ☐ (LIGHT/OCCASIONAL) ☐ (FORMER) ☐ (NEVER) ☐ PREGNANT/NURSING MOTHER: ☐

ALLERGIES: ☐ (IF YES, PLEASE LIST) _____

MEDICATIONS: ☐ (IF YES, PLEASE LIST ALL CURRENT PRESCRIPTIONS, ORAL CONTRACEPTIVES, AND OVER THE COUNTER MEDICATIONS INCLUDING ASPIRIN)

_____

_____

_____

ACKNOWLEDGEMENT OF PRIVACY POLICY AND HEALTH INFORMATION RELEASE

PERMISSION TO RELEASE HEALTH INFORMATION TO: _____

PLEASE LIST ANY FAMILY MEMBERS/FRIENDS THAT YOU WOULD LIKE TO PERMIT ACCESS TO YOUR PROTECTED HEALTH INFORMATION. DUE TO THE HIPAA PRIVACY POLICY, WE CAN **ONLY** RELASE YOUR INFORMATION TO WHOEVER IS LISTED ABOVE .

SIGNATURE: _____ RELATIONSHIP TO PATIENT: _____

I ACKNOWLEDGE THAT I HAVE RECEIVED AND AGREE TO THE ***NOTICE OF PRIVACY PRACTICES*** FROM COX EYE CARE

(IF UNDER 18, M,UST BE LEGAL PARENT OR GUARDIAN)

DATE: ____/____/____

CURRENT EYE HEALTH AND OCULAR HISTORY

CURRENTLY WEARING (CHOOSE ALL THAT APPLY): ☐ GLASSES ☐ CONTACT LENSES

DO YOU EXPERIENCE ANY OF THE FOLLOWING?
(CHOOSE ALL THAT APPLY. INCLUDE SYMPTOMS THAT CCUR WHILE USING GLASSES OR CONTACTS, IF ANY)

- ☐ BLURRING AT DISTANCE
- ☐ BLURRING AT NEAR
- ☐ LOSS OF SIDE VISION
- ☐ NIGHT VISION PROBLEMS
- ☐ DOUBLE VISION
- ☐ EYE DISCOMFORT OR PAIN
- ☐ REDNESS
- ☐ SANDY OR GRITTY FEELING
- ☐ ITCHING
- ☐ BURNING
- ☐ MUCUS OR MATTERING
- ☐ EXCESSIVE WATERING
- ☐ SPOTS FLOATING
- ☐ FLASHES OF LIGHT
- ☐ DRYNESS
- ☐ LIGHT SENSITIVITY

HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?

- ☐ CATARACTS
- ☐ CROSSED EYES
- ☐ DRY EYE
- ☐ EYE INFECTION
- ☐ EYE INJURY
- ☐ GLAUCOMA
- ☐ MACULAR DEGENERATION
- ☐ LAZY EYE/AMBLYOPIA
- ☐ RETINAL DETACHMENT
- ☐ RETINAL DISEASE

INTERESTED IN CONTACT LENSES: ☐ YES ☐ NO ☐ MAYBE

FAMILY HEALTH HISTORY

HAVE ANY OF YOUR FAMILY MEMBERS BEEN DIAGNOSED WITH:

(CHECK IF YES)	RELATIONSHIP TO PATIENT: (PARENTS, GRANDPARENTS, SIBLINGS, AND CHILDREN)
☐ GLAUCOMA	
☐ CATARACTS	
☐ MACULAR DEGENERATION	
☐ CROSSED EYES/LAZY EYE	
☐ RETINAL DAMAGE/DISEASE	
☐ HYPERTENSION	
☐ DIABETES	
☐ ARTHRITIS	
☐ CANCER	
☐ THYROID DISEASE	
☐ HEART DISEASE	

REVIEW OF SYMPTOMS

(CHECK IF YES, CHOOSE ALL THAT APPLY)

ALLERGIC/IMMUNOLOGIC:
- ☐ ENVIRONMENTAL ALLERGY
- ☐ RHEUMATOID ARTHRITIS
- ☐ LUPUS

MUSCULOSKELETAL:
- ☐ FIBROMYALGIA
- ☐ MUCULAR DYSTROPHY
- ☐ ARTHRITIS

CARDOVASCULAR/CARDIAC:
- ☐ HEART DISEASE
- ☐ HYPERTENSION
- ☐ STROKE
- ☐ VASCULAR DISEASE

GASTROINTESTINAL:
- ☐ CROHN'S DISEASE/IBS
- ☐ COLITIS
- ☐ ULCER

NEUROLOGICAL:
- ☐ MULTIPLE SCLEROSIS
- ☐ EPILEPSY
- ☐ ALZHEIMER'S
- ☐ PARKINSON'S
- ☐ MIGRAINES

CONSTITUTIONAL:
- ☐ DEVELOPMENTAL DISABILITY
- ☐ FATIGUE

GENITOURINARY:
- ☐ STD, VIRAL HERPETIC, CHLAMYDIA
- ☐ KIDNEY DISEASE
- ☐ OVARIAN/UTERINE CANCER
- ☐ PROSTATE CANCER

PSYCHIATRIC:
- ☐ DEPRESSION
- ☐ PANIC DISORDER
- ☐ SCHIZOPHRENIA

EAR, NOSE, MOUTH, AND THROAT:
- ☐ RINGING/TINITIS
- ☐ DRY THROAT/MOUTH OR CHRONIC COUGH

HEMATOLOGIC/LYMPHATIC:
- ☐ ANEMIA
- ☐ BLEEDING DISORDER
- ☐ LEUKEMIA

RESPIRATORY:
- ☐ ASTHMA
- ☐ EMPHYSEMA

ENDOCRINE:
- ☐ NON-INSULIN DEPENDENT (II) DIABETES
- ☐ INSULIN DEPENDENT (I) DIABETES
- ☐ THYROID DYSFUNCTION

INTEGUMENTARY:
- ☐ ECZEMA
- ☐ ROSACEA
- ☐ PSORIASIS
- ☐ SKIN CANCER

OTHER: _____

SPECIAL EYEWEAR NEEDS

(CHOOSE ANY THAT APPLY)

- ☐ COMPUTER (SPECIAL PRESCRIPTIONS, ANTI-GLARE COATING)
- ☐ SAFETY (GARDENING,WOODWORKING,WELDING)
- ☐ SPORTS/HOBBIES (SWIMMING/SPORTS GOGGLES, SKI MASKS, MOTORCYCLE)
- ☐ OCCUPATIONAL (MECHANICS,PLUMBERS,PILOTS)