PATIENT INFORMATION RECORD
(PLEASE PRINT)

TODAY'S DATE________________

MR.___MRS.___MISS___MS.___DR.___PATIENT'S NAME____
(First) (MI) (Last)

ADDRESS__________________________________Apt#_______CITY_____________________ST_____ZIP_________

PHONE # (___)_____________________(___)_______________________Dept./Ext.________(__)_________________
(Home) (Work) (Cell)

SOCIAL SECURITY #_______-________-_______ MALE ______FEMALE_______DATE OF BIRTH____________________

PATIENT STATUS: MARRIED___SINGLE___WIDOW___DIVORCED___OTHER______ EMPLOYED/STUDENT/RETIRED
(Circle one)

EMPLOYER/SCHOOL NAME: ____Occupation____________________

HOW DID YOU HAPPEN TO COME TO THIS OFFICE? (CHECK ALL THAT APPLY) Website________ A Doctor____________

Saw our Sign______ Insurance List_____ A Friend/Relative (name)_______________________ Other___________________

Email Address: ________________________________

PATIENT MEDICAL INFORMATION

WHAT EYE PROBLEMS ARE YOU HAVING? ____

____

____

WHEN WAS YOUR LAST EYE EXAMINATION? _____________PREVIOUS EYE DOCTOR? ______________________

DO YOU NOW OR HAVE YOU EVER WORN ( ) GLASSES ( ) CONTACT LENSES

ARE YOU INTERESTED IN CONTACT LENSES TODAY? ( ) YES ( ) NO

Please check box if applicable & provide details.

1. **PAST EYE HISTORY:** **EXPLANATION: (WHEN?)**

( ) INJURY ( ) TUMOR ( ) SURGERY ( ) CROSSED EYE ____________________________________
( ) DISEASE ( ) AMBLYOPIA(LAZY EYE) ( ) DRY EYES ____________________________________
( ) CATARACTS ( ) RETINA PROB. ( ) GLAUCOMA ____________________________________
( ) NO PREVIOUS INJURY/DISEASE ( ) OTHER ____________________________________

2. **LIST ALL MEDICATIONS AND VITAMINS YOU ARE TAKING**

____

____

3. **ARE YOU ALLERGIC TO ANY MEDICATIONS? ( ) YES ( ) NO**

IF YES, WHICH ONES/WHAT HAPPENS? ____

PRIMARY CARE PHYSICIAN: _____________________________________ Date of last visit________________

4. **YOUR PAST MEDICAL HISTORY: (Check box if applicable & provide details.) EXPLANATION: (WHEN?)**

( ) DIABETES ( ) SURGERY ( ) BACK/NECK DISORDERS ____________________________________
( ) ENDOCRINE (GLANDS) ( ) NEUROLOGICAL DISORDERS ____________________________________
( ) STROKE ( ) CANCER ( ) RESPIRATORY DISORDERS ____________________________________
( ) HIGH BLOOD PRESSURE ( ) VASCULAR DISORDER ____________________________________
( ) HEART DISORDERS ( ) EMOTIONAL DISORDERS ____________________________________
( ) URINARY DISORDERS ( ) ARTHRITIS ____________________________________
( ) THYROID CONDITION ( ) HIGH CHOLESTEROL ____________________________________
( ) ALLERGIES ( ) OTHER ( ) HIV/ AIDS ____________________________________
( ) USE OF NICOTINE ( ) USE OF ALCOHOL ( ) OTHER DRUGS

RATE YOUR GENERAL HEALTH: Circle one POOR FAIR GOOD EXCELLENT

5. **YOUR FAMILY EYE HISTORY: (Check box if applicable & provide details.) EXPLANATION: (MOTHER, FATHER, ETC.)**

( ) GLAUCOMA ( ) DIABETES ( ) CROSSED EYE ____________________________________
( ) EYE CANCER ( ) CATARACT ( ) RETINA PROBLEMS ____________________________________
( ) HIGH BLOOD PRESSURE ( ) OTHER ____________________________________

PATIENT INSURANCE INFORMATION

VISION INSURANCE CO. NAME: ____________________

INSURED NAME: ____________________ **INSURED D.O.B** ____________________

EMPLOYER ____________________ **RELATIONSHIP TO PATIENT** ____________________

IDENTIFICATION # ____________________ **GROUP#** ____________________ **INSURED_SSN:** ____________________

Vision Insurance Disclaimer: **Would you like your personal medical information shared with your vision carrier?**
YES_________ **NO**_________**(Recommended)**

MEDICAL INSURANCE:

MEDICARE: TRICARE: MEDICAID: ANTHEM: CIGNA: UHC: AETNA:
OPTIMA: AARP: OTHER INSURANCE: ____________________

INSURED NAME: ____________________ **POLICY #** ____________________ **INSURED D.O.B.** ____________________

WHO IS RESPONSIBLE FOR THE PATIENT DUE BALANCE?

Relationship to Patient: Self _____ Spouse _____ Father ____Mother _____Other ____________________

(**REQUIRED** IF PATIENT IS UNDER 18 YEARS OF AGE OR SOMEONE OTHER THAN THE PATIENT IS RESPONSIBLE)

NAME: ____________________
(First) (MI) (Last)

ADDRESS: ____________________
____

OCCUPATION: ____________________

DOB: ____________________

SSN: ____________________

HOME PHONE: ____________________

WORK/CELL: ____________________

EMPLOYER: ____________________

PATIENT'S/INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize Dr. Seim & Associates to furnish information to insurance carriers including Social Security Administration or its intermediaries of carrier, concerning my illness and treatment. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party that accepts assignment. I understand that my insurance is a contract between me and my insurance carrier. I UNDERSTAND THAT I AM RESPONSIBLE FOR THIS ACCOUNT. I understand that if Dr. Seim & Associates do not receive a response from my insurance company within 60 days of filing my claim, I am responsible for payment of this account in full. I understand that I am responsible for any amount not covered by insurance. In the event of default on any payment due, I agree to pay all costs of collection, including attorney fees of 33 1/3% on the amount due at the time of default. In the event that my check is returned for non-sufficient funds, I agree to pay a $35.00 fee. We may electronically debit or draft your account for this charge. Also, if your check is returned for insufficient or uncollected funds, your check may be electronically re-presented for payment.

X ____________________

(DATE) (PATIENT/GUARANTOR) (RELATIONSHIP TO PATIENT)

THIS OFFICE MAINTAINS YOUR PATIENT RECORDS FOR AT LEAST 5 YEARS FROM LAST DATE OF PATIENT ENCOUNTER. AFTER THAT TIME, THIS OFFICE MAY DESTROY YOUR RECORDS IN A MANNER WHICH PROTECTS PATIENT CONFIDENTIALITY.

Revised 07-30-2020