Welcome to Siskiyou Eye Center

We are happy you have chosen us for your eye care! We are committed to providing quality care and efficient service. Your help with the following will enable us to meet these goals:

Checking in:

You will be asked to present your insurance card[s] when you check in. We are required by most insurance carriers, Medicare being one of them, to maintain a copy of your card in your chart. Without this, we will be unable to bill your insurance for your visit.

We will also take your picture when you check in. The picture is appended to your chart ~ we use it to make sure no one else is checking in using your name or insurance/financial information. We are committed to protecting your health and financial information.

Billing Secondary Insurance:

Most secondary insurances are part of a 'cross-over system' with Medicare. If yours is not, then you will have to bill your secondary. As a courtesy, we will gladly bill your secondary insurance if a surgery is performed.

Medications:

Please bring a list of any medications you may be using. This is important information and will become part of your medical record with us.

Optical Department:

We take great pride in both of our optical departments. We are pleased to offer a large selection of spectacle styles and lens types to suit most everyone's needs, as well as a large selection of contact lenses. Our opticians are committed to providing quality service and quality products to our patients.

We are VSP providers. Please be sure to let our staff know if you have this coverage.

We look forward to serving you!

PATIENT INFORMATION SHEET

Patient's First Name:_______________ Middle Initial: ____ Last Name: _______________________

Social Security # [*needed for insurance purposes*]: ____

Mailing Address: __________________________ ***email address:*** ______________________________

City: ____________________________ State: ______________ Zip: ________________________

Sex: M/F Date of Birth: ________ Age: ____ Home Phone: _______________ Cell: _____________

Single Married Divorced Widowed Separated

Emergency Contact: ________________________ Phone #: __________________________________

- *Caregiver's Name and Phone #:* ____

Patient's Employer: ____________________________ Work #: ________________________________

- **IF MARRIED:** Spouse's Name: ____________________Employer:__________________________

Primary Insurance: __________________________Secondary Insurance: ______________________

Complete below IF POLICY HOLDER IS OTHER THAN SELF

Name of Policy Holder **#1:** _____________________________ Date of Birth: ______________________

SS# __________________________Employer: ______________________Work # ______________

Relationship to Patient: ___________________Primary Insurance:__________________________

Name of Policy Holder **#2:** _____________________________ Date of Birth: ______________________

SS# __________________________Employer: ______________________Work # ______________

Relationship to Patient: ___________________Secondary Insurance:__________________________

Thank you!

MEDICAL HISTORY QUESTIONNAIRE

Name: ____ Nickname: ____________________________ Date of Birth: ____/____/______

Primary Care Physician: __________________________________Referring /Specialty Dr.________________________________

Pharmacy:_____________________________________ Location(street & city) ____

Race: □ American Indian or Alaska Native □ Asian □ Black or African American

□ Native Hawaiian or Other Pacific Islander □ White

Ethnicity: □ Hispanic □ Not Hispanic

Preferred Language: □ English □ French □ Italian □ Japanese □ Portuguese

□ Russian □ Spanish

AllERGIES: Reaction Severity

___________________________ ________________________________ mild / moderate / severe

___________________________ ________________________________ mild / moderate / severe

___________________________ ________________________________ mild / moderate / severe

___________________________ ________________________________ mild / moderate / severe

Past Ocular History: (Please mark all that apply)

□ Overall Healthy
□ Amblyopia (Lazy eye)
□ Aphakia
□ Astigmatism
□ Cataracts
□ Diabetic Retinopathy
□ Dry Eyes
□ Glaucoma
□ Hyperopia (Far sighted)
□ Iritis
□ Keratoconus
□ Macular Degeneration
□ Myopia (Near sighted)
□ Optic Neuritis
□ Retinal Detachment

Other____

Ocular Surgeries: (Please mark all that apply)

□ No prior ocular surgery
□ Blepharoplasty
□ Cataract Surgery
□ Corneal Transplant
□ Foreign Body Removal
□ Retinal Laser Surgery
□ LASIK
□ PRK
□ Punctal Plugs
□ RK
□ Strabismus Surgery (eye muscle surgery)
□ Trabeculectomy (Glaucoma surgery)
□ Vitrectomy

Other____

Ocular Significant Illnesses: (Please mark all that apply)

□ Overall Healthy
□ AIDS
□ Diabetes
□ Rheumatoid Arthritis
□ Herpes
□ HIV Positive
□ Hypertension
□ Hypothyroidism
□ Lupus
□ Multiple Sclerosis
□ Sjogrens
□ Graves Disease
□ Hyperthyroidism

Other____

Current Eye Medications: (Please list)

____

____

____

Systemic Illnesses:

□ No history of illnesses
□ Anemia
□ Arthritis
□ Arrhythmia
□ Asthma
□ Bleeding Disorder
□ Cancer
□ Thyroid Disease
□ Congestive Heart Failure
□ COPD
□ Diabetes
□ Eczema
□ Fibromyalgia
□ Headache
□ Hearing Loss
□ Hepatitis
□ High Blood Pressure
□ High Cholesterol
□ HIV
□ Kidney Disease
□ Kidney Stones
□ Liver Disease
□ Lung Disease
□ Lupus
□ Migraine
□ Polymyalgia
□ Psychiatric Disorder
□ Skin Cancer
□ Stroke

Other____

General Surgeries / Operations: (Please list)

____

____

____

Please continue on the back side of this page →

Current Other Medications: (Please list)

____

____

____

Infections: (Please mark all that apply)

□ Overall Healthy
□ Chicken Pox
□ Hepatitis A / B / C
□ Herpes Simplex
□ Herpes Zoster / Shingles
□ Histoplasmosis
□ HIV / AIDS
□ Meningitis
□ MRSA
□ Syphillis
□ Toxoplasmosis
□ Wound Infection

Other____

Family History:

□ Arthritis
□ Blindness
□ Cancer
□ Cataracts
□ Diabetes
□ Glaucoma
□ Heart Disease
□ High Blood Pressure
□ Kidney Disease
□ Lazy Eye
□ Macular Degeneration
□ Retinal Disease
□ Stroke
□ TB

Other____

Social History: (Please mark all that apply)

Smoking: □ current every day smoker □ current some day smoker □ former smoker □ never smoked

Alcohol Use: □ Yes □ No If yes how much and how often?____

Drug Use: □ Yes □ No If yes what and how often?____

Review of Systems: (Please mark all that apply)

Eyes
□ Previous Surgery
□ Contact Lens
□ Pain
□ Double Vision
□ Glaucoma
□ Cataracts
□ Macular Degeneration
□ Dry Eyes
□ Flashes
□ Floaters

Ear, Nose, and Throat
□ Hard of Hearing
□ Ringing in Ears
□ Vertigo

Cardiovascular
□ Chest Pain
□ Dizziness
□ Fainting Spells
□ Shortness of Breath
□ Irregular Heart Beat
□ Difficulty Lying Flat

Constitutional
□ Fatigue / Weakness
□ Fever
□ Weight Gain / Loss

Respiratory
□ Cough
□ Congestion
□ Wheezing
□ Asthma

Gastrointestinal
□ Heartburn
□ Nausea / Vomiting
□ Jaundice / Hepatitus

Genito-Urinary
□ Pain / Difficulty
□ Blood in Urine
□ History of Kidney Stones
□ History of STD's

Psychiatric
□ Anxiety / Depression
□ Mood Swings
□ Difficulty Sleeping

Endocrine
□ Increased Thirst
□ Increased Hunger
□ Increased Urination
□ Increased Sweating
□ Fingernail Changes

Blood / Lymphnodes
□ Easy Bruising
□ Gums Bleed Easy
□ Prolonged Bleeding
□ Heavy Aspirin Use

MusculoSkeletal
□ Stiffness
□ Arthritis
□ Joint Pain / Swelling

Skin
□ Rash / Sores
□ Lesions
□ Hives / Eczema

Neurological
□ Seizures
□ Weakness / Paralysis
□ Numbness
□ Tremors

Immunologic
□ Hives
□ Itching
□ Runny Nose
□ Sinus Pressure