Martinsburg Eye Associates, PLLC

Patient Information

Name Last:____________________________First:______________________Middle:____________________

Date Of Birth:__________________________Marital Status:____

Address:____

City:____State:______________Zip Code:_____________________

Email:____

Cell Number:____________________________Other Phone Number_________________________________

Occupation:______________________________Employer:____

Emergency Contact:_______________________________________Phone Number:______________________

If Minor Parent's Name:____

Name of Family Physician:____

Name of Optometrist:____

Insurance Information

Policy Holder's Name: ___Self **or** Last Name: ____________________First Name: ___________________

Date of Birth: _______________________Relationship: ____

Insurance Carrier: __________________________________Policy Number:___________________________

Lifetime Authorization and Assignment of Benefits

I hereby authorize the physicians and staff of Martinsburg Eye Associates, PLLC to perform such treatments to me as may be prescribed by my attending physician during any and all my visits to Martinsburg Eye Associates, PLLC. I understand that I am financially responsible for all charges arising from services rendered to me by Martinsburg Eye Associates, PLLC. I hereby authorize Martinsburg Eye Associates, PLLC to file on any and all insurance for any charges that I incur. I request that all payments from any of these insurance's be mailed directly to Martinsburg Eye Associates, PLLC. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, or any insurance company, any information needed to determine these benefits or the benefits payable for related services.

$40 fee for New Glasses Prescription is NOT covered by Insurance.

I acknowledge that I received a copy of Notice of Privacy Practices.

Patient's Signature:____Date:__________________________

Name:____Date:_____________

Reason For Today's Visit:

____

____

List All Medical Conditions, including eye conditions:

____

____

List All Previous Surgeries, including eye surgeries:

____

____

Pharmacy:____**Phone:**______________________

Pharmacy Location:____

Allergies: **No** **Yes** ____

Family History:

Blindness____, Glaucoma____, Macular Degeneration____, Diabetes____, Stroke____,Heart Disease____, Cancer____, Other heritable disease:______________________

Social History:

Do you drink? Yes____ No____ if yes, how much? _____________

Do you smoke? Yes____ No____ if yes, how much? _____________

General:	**Yes**	**No**
Fever	___	___
Weight loss	___	___
MRSA infection	___	___
Cardiovascular:		
High BP	___	___
Heart problems	___	___
Respiratory:		
Congestion	___	___
Wheezing	___	___
Shortness of breath	___	___
Gastrointestinal:		
Diarrhea/constipation	___	___
Ulcers	___	___
Female:		
Pregnant/nursing	___	___

	Yes	**No**
Blood/Lymphatic:		
Bleeding Disorder	___	___
Endocrine:		
Diabetes	___	___
Thyroid	___	___
Skin:		
Rash	___	___
Neurologic:		
Seizures	___	___
Paralysis	___	___
Psychiatric:		
Depression	___	___
Anxiety	___	___