

**WELCOME TO  
ARROW EYE CARE**

**PATIENT INFORMATION**

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ City, State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Hm Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_ M \_\_\_ F \_\_\_  
Employer / Occupation: \_\_\_\_\_ Hobbies: \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_ Have you been here before? \_\_\_\_\_

**EYE / MEDICAL / SOCIAL HISTORY**

What is your reason for today's visit? \_\_\_\_\_  
Date of last eye exam: \_\_\_\_\_ Eye Doctor: \_\_\_\_\_ Wears soft contacts \_\_\_\_\_ hard contacts \_\_\_\_\_ glasses \_\_\_\_\_  
List all medications you are currently taking: \_\_\_\_\_  
List all medications you are allergic to: \_\_\_\_\_

**Please check all that apply:**

Cataracts	___ Me ___ Family	Diabetes	___ Me ___ Family
Macular Degeneration	___ Me ___ Family		___ Insulin ___ Non-insulin
Glaucoma	___ Me ___ Family	Hypertension	___ Me ___ Family
Lazy Eye	___ Me ___ Family	Thyroid Disease	___ Me ___ Family
Eye Injury/Surgery	___ Me ___ Family	Cancer	___ Me ___ Family
Dry eyes	___ Me	Headaches	___ Me
Other conditions	_____		

**\*\* RETINAL IMAGING**

Our new improved standard of care includes a retinal image on all patients age 40 and over. This is crucial to detect health conditions related to the eye, such as hypertension, high cholesterol, diabetes, and other potential vision-threatening diseases. This test takes the place of dilation in most cases.

Vision insurance plans do not cover this retinal screening, so there will be an **additional fee of \$30.**

**\*\* PAYMENT (Due as services are rendered)**

Vision Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_  
**Policy Holder's Name:** \_\_\_\_\_ M \_\_\_ F \_\_\_  
Relationship to Patient: Self \_\_\_ Spouse \_\_\_ Child \_\_\_ Other \_\_\_ SSN: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Address (if different): \_\_\_\_\_ ZipCode: \_\_\_\_\_  
RESPONSIBLE FOR PAYMENT Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Birthdate: \_\_\_\_\_

I authorize the release of medical information to process insurance claims and payment of benefits made directly to Arrow Eye Care for services provided to me. I understand I am financially responsible for charges not covered by this assignment. I authorize any remaining balance to be charged to the credit card on file.

**\*\* PLEASE SIGN:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**PATIENT PRIVACY NOTICE**

Please read a copy of the privacy laws for your information.

**By signing below, I have been informed of Arrow Eye Care's Patient Privacy Notice.**

**\*\* PLEASE SIGN:** \_\_\_\_\_ **DATE:** \_\_\_\_\_