110 E Ryder Street, Litchfield, IL 62056
217.324.2762 (P) 217.324.2086 (F)

Today's Date: _____ **E-mail:** _____

Primary Care Physician: _____ **Pharmacy**: _____

First name: _____ Initial: _____ Last: _____

Date of Birth: _____ Age: _____ Gender: _____ F _____ M Marital Status: _____ S _____ M _____ D _____ W

Address: _____ City: _____ State/Zip: _____

Telephone: _____ Cell: _____ Work: _____

Race: _____ Last 4 of Social Security Number: _____ Pronoun: _____

Insurance Information

Vision Insurance: _____ Member ID: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Subscriber SS # (last 4 digits): _____

Primary Health Insurance

Company Name: _____ Member ID: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Subscriber SS # (last 4 digits): _____

Secondary Insurance

Company Name: _____ Member ID: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Subscriber SS # (last 4 digits): _____

Financial Assignment Information:
I understand and agree that health insurance policies are an arrangement between an insurance carrier and me. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care care/treatment, any fees for profession services rendered to me will be immediately due and payable.

( ) Yes, I have read or had explained to me, by this office, the NPP and I wish to continue my care under said terms.
( ) No, I have not read this offices NPP, but was given the opportunity to read it and declined. I wish to continue my care under said terms.
( ) The NPP could not be read due to the emergent nature of the care needed.

Signature: _____ **Date:** _____

What concerns do you have about your vision/eyes? _____

Do you now or have you ever worn glasses? Yes ____ No ____ if so, how old are your glasses? _____

Do you now or have you ever worn contacts? Yes ____ No ____ If so, how long? _____

Are you diabetic? Yes ____ No ___

Please list any major surgeries you have had: _____

Have you had cataract surgery? Yes ____ No ____ Have you had Lasik surgery? Yes ___ No ___

If yes, who was your surgeon and dates of surgery? _____

May we call your primary care physician and request your medication list? Yes ____ No ____

Medical History	**Self**	**Mom**	**Dad**	**Brother**	**Sister**	**Grandmother**	**Grandfather**
Alzheimer's	○	○	○	○	○	○	○
Arthritis/RA	○	○	○	○	○	○	○
Autism	○	○	○	○	○	○	○
Cataracts	○	○	○	○	○	○	○
Diabetes	○	○	○	○	○	○	○
Dementia	○	○	○	○	○	○	○
Glaucoma	○	○	○	○	○	○	○
Heart Disease	○	○	○	○	○	○	○
High Cholesterol	○	○	○	○	○	○	○
Hypertension	○	○	○	○	○	○	○
Hyperthyroidism	○	○	○	○	○	○	○
Hypothyroidism	○	○	○	○	○	○	○
Lupus	○	○	○	○	○	○	○
Macular Degen	○	○	○	○	○	○	○
Multiple Sclerosis	○	○	○	○	○	○	○
Myasthenia Gravis	○	○	○	○	○	○	○

Please list your medications (including eye drops) or you may provide a list

_____ _____ _____ _____ _____

NO Medications _____

Drug Allergies: _____ _____ _____ _____

NO Drug Allergies: _____

Smoke: Yes _____ No _____ Former _____ Alcohol: Yes _____ No _____ Social _____

Release of Medical Information:

I, _____, give permission to Reid Eye Care to release my medical information to the following family members:

_____ _____ _____ **DECLINE:** _____