EYECONiC eyecare
18931 E Valley view Parkway, Suite H
Independence, MO 64055
816.795.8884 Fax 816.795.8935
eyeconiceyecare.com

PATIENT INFORMATION

Name (Last, First, Middle Intial)	Date of Birth	Social Security #	Sex
Address	Home Phone	Cell Phone	Work Phone
City, State, Zip	Primary Employer		
E-Mail Address	Employer Address		
Primary Care Physcian	Employer City, State, Zip		
Referred By	Secondary Billing Address (if Applicable)		
Type of Visit: ☐ Routine ☐ Medical *Contact Lenses:* ☐ Yes ☐ No	City, State, Zip		

RESPONSIBLE PARTY INFORMATION

Name (Last, First, Middle Intial)	Social Security #	Date of Birth	Sex
Address	Emergency Contact		
City, State, Zip	Address		
Home Phone	City, State, Zip		
Relationship To Patient	Home Phone		

PRIMARY INSURANCE

Name of Insurance Company	Policy# / ID #	
Name of Insured	Group #	
Address of Insurance Company	Co-Pay Amount	
City, State, Zip	Insured Social Security #	Insured Date of Birth
Relationship to Patient	Effective Date	Expiration Date

SECONDARY INSURANCE

Name of Insurance Company	Policy# / ID #	
Name of Insured	Group #	
Address of Insurance Company	Co-Pay Amount	
City, State, Zip	Insured Social Security #	Insured Date of Birth
Relationship to Patient	Effective Date	Expiration Date

I authorize the release of any information, including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or health practioners. I authorize my insurance benefits be paid directly to the physcian. I understand that I am responsible for all co-pays, deductibles and co-insurance amounts.

Signature of Patient / Guardian

Date

HEALTH HISTORY

NAME: DATE:

OCULAR HISTORY

	YES	NO		YES	NO	
Cataracts	☐	☐	Injury_____	☐	☐	Cataract Surgery_____
Glaucoma	☐	☐	Iritis	☐	☐	Retina Surgery_____
Retina Disease	☐	☐	Crossed / Lazy Eye	☐	☐	Lasik_____
Cornea Disease	☐	☐	Other_____	☐	☐	

MEDICATIONS

ALLERGIES

MEDICAL HISTORY

	YES	NO		YES	NO
Asthma	☐	☐	Head or Spinal Injuries	☐	☐
COPD / Emphysema	☐	☐	Seizures	☐	☐
Tuberculosis	☐	☐	Arthritis	☐	☐
Kidney Disease	☐	☐	HIV / AIDS	☐	☐
Diabetes	☐	☐	Ulcer	☐	☐
Thyroid	☐	☐	Sickle Cell Anemia	☐	☐
Migraines	☐	☐	Psychiatric	☐	☐
Heart Disease	☐	☐	Prolonged Steroid Use	☐	☐
High Blood Pressure	☐	☐	Pregnant	☐	☐
Stroke	☐	☐	Smoke	☐	☐
Carotid Artery Disease	☐	☐	Drink Alcohol	☐	☐
High Cholesterol	☐	☐	Illegal Substances	☐	☐
Cancer	☐	☐	Other_____	☐	☐

SURGICAL HISTORY

FAMILY HISTORY

Indicate relationship to patient: F - Father M - Mother S - Sister B - Brother GF - Grandfather GM - Grandmother

	YES	NO		YES	NO
Glaucoma	☐	☐	Diabetes	☐	☐
Cataracts	☐	☐	Heart Problems	☐	☐
Cornea Disease	☐	☐	Stroke	☐	☐
Macular Degeneration	☐	☐	High Blood Pressure	☐	☐
Retinitis Pigmentosa	☐	☐	Asthma / COPD / Emphysema	☐	☐
Other Eye Problems_____	☐	☐	Other general health problems	☐	☐

By my signature, I verify That I Have received or was offered a copy of EYECONiC eyecare's Notice of Privacy Practices. Only those whom I list in the space provided are authorized to discuss my medical care or billing with an EYECONiC eyecare representative.

Signature of Patient / Guardian

Date