Woodward Vision Care

CLEAR VISION BEGINS WITH HEALTHY EYES

Patient No. _____

Patient Information Thank you for choosing our practice for your eye care needs. Please complete this form.

If you have any questions or concerns, do not hesitate to ask for assistance. We would be happy to help!

(Please print)

Name _____ Date _____

Birth date _____M / F Age _____ Social Security # _____

Address _____ City _____State _____ Zip _____

Home Phone # _____ Work # _____ Cell # _____

Primary Care Physician _____ PCP phone # _____

Pharmacy _____ Pharmacy Phone # _____

Do you prefer to receive calls at: ▫Home ▫Work ▫Cell

Are You: ▫MINOR ▫Married ▫Divorced ▫Widowed ▫Single

Preferred Language ▫ English ▫ Spanish ▫ Other _____

Race _____ Ethnicity _____

Communication Preference ▫ E-mail ▫ Postal ▫Telephone

E-Mail Address _____ Receive Text messages ▫ YES ▫ NO

Your Employer _____ Occupation _____

Business Address _____ City _____ State _____ Zip _____

Spouse's Name _____ Workplace _____ Work#_____

RESPONSIBLE PARTY

Name of person responsible for account? _____

Relationship to patient _____ Phone # _____

Address _____ City _____ State_____ Zip _____

Name of Employer _____ Work # _____

INSURANCE INFORMATION

Insurance Company _____ ID# _____ Group # _____

Name of insured _____ Relationship to patient _____

Insured Birth date _____ Insured Social Security # _____

Do you have additional insurance? ▫ YES ▫ NO If yes, please provide a copy of card

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Patient History Record

Age: _____ Date: _____

Name: _____

(Last) (First) (DOB)

Please answer the following questions about your medical status and history:

1. Have you ever been treated for any medical conditions (diabetes, high blood pressure, arthritis, act.)?

Yes ▫ No▫ If yes, please explain: _____

_____

1. Have you ever had any eye disease (glaucoma, cataract, wandering or "lazy" eye,

Retinal detachment)? Yes ▫ No ▫ if yes, please explain:
_____

_____

1. Have you ever had eye surgery?

Yes ▫ No ▫ if yes, please provide date and reason:
_____

_____

1. Do you have any drug or food allergies?

Yes ▫ No ▫ if yes, please list
_____

Chief Complaint: _____

_____

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Please list any problems you have had in the past or present.

Eyes

Health

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Patient Medication List

Patient Name: _____ Date: _____

Do you take any medications? Yes ▫ No ▫

If Yes, please list all medications including non-prescription medicines

(Example: aspirin, Tylenol, Vitamins, ect.)

Medicine Name	**Dosage**	**Frequency**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Acknowledgement of Receipt

I acknowledge that I received a copy of

Dr. Jimmy D. Smart, O.D. and/or Dr. Trey D. Carlisle, O.D.'s

Notice of Privacy Practices.

Patients Printed Name_____

Signature: _____ Date: _____

WHOM MAY WE THANK FOR REFERRING YOU TO WOODWARD VISION CARE?

DOCTOR/PROFESSIONAL _____

FAMILY/FRIEND _____

OR CHECK ONE: ▫ RADIO ▫NEWSPAPER ▫ YELLOWPAGES/INTERNET

Other Insurance:

I hereby authorize payment of my vision, medical and surgical insurance benefits to Dr. Jimmy D. Smart, O.D. and/or Dr. Trey D. Carlisle, O.D.. I understand I am financially responsible for any charges whether or not paid by said insurance. I agree to pay any co-payments and/or deductibles to Dr. Jimmy Smart and/or Dr. Trey Carlisle. I authorize Dr. Jimmy D. Smart and/or Dr. Trey Carlisle to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization maybe used in place of the original.

_____ _____

Patient's (or legal guardian's) signature Date