PATIENT INFORMATION — PLEASE PRINT

LAST NAME	FIRST NAME	MI	PATIENT'S SOCIAL SECURITY NUMBER

PATIENT'S DATE OF BIRTH	SEX	MARITAL STATUS	STUDENT STATUS
	F M	S M W DIV SEP	FULL TIME PART TIME

STREET ADDRESS	CITY	STATE	ZIP

RACE (Government requested) PLEASE CIRCLE ONE					
BLACK OR AFRICAN AMERICAN	WHITE	HISPANIC	AMERICAN INDIAN	ASIAN	INDIAN
NATIVE ALASKAN	NATIVE HAWAIIAN	PACIFIC ISLANDER	GREEK	MULTIRACIAL	OTHER

PRIMARY LANGUAGE (Government requested)			
OCCUPATION		EMPLOYER NAME	

PRIMARY CARE PHYSICIAN	DIABETIC OR RHEUMATOLOGY SPECIALIST YES OR NO

HOME PHONE	CELL PHONE	WORK PHONE	E-MAIL ADDRESS	CONTACT PREFERENCE
( )	( )	( )		HOME CELL WORK

INSURANCE INFORMATION
PLEASE PRESENT INSURANCE CARDS AT CHECK-IN

GUARANTOR INFORMATION (PERSON RESPONSIBLE FOR PAYMENT)

LAST NAME	FIRST NAME	MI

DATE OF BIRTH	SEX	RELATIONSHIP TO PATIENT
	F M	SELF SPOUSE PARENT OTHER

HOME ADDRESS (IF DIFFERENT FROM PATIENT)	CITY	STATE	ZIP	HOME PHONE
				( )

EMPLOYER	WORK PHONE
	( )

EMERGENCY INFORMATION

NAME	RELATIONSHIP	HOME PHONE	CELL PHONE

Please complete reverse side

INSURANCE AUTHORIZATION

As a courtesy to our patients we will file claims to your insurance company with the information you provide at the time of service. Due to the ever-changing nature of insurance we are unable to guarantee payment by your insurance company. We will be glad to try and help you with your insurance questions but it is ultimately the patient's responsibility to know and follow any policy guidelines and restrictions of your particular policy.

- **I understand that I remain financially responsible for all medical fees incurred for services rendered by Iowa Eye Center and agree to pay, all charges not covered by insurance and any applicable co-payments and/or deductibles.**
- **I authorize the release of any medical or other information necessary to process insurance claims for services rendered by Iowa Eye Center.**
- **I authorize payment of medical and/or vision benefits directly to Iowa Eye Center for services rendered.**

X ____

Patient or Authorized Representative **Date**

If you have Medicare please complete the following:

Are you (or your spouse) currently working?	**Yes**	**No**
Are you receiving benefits under an employer's disability policy?	**Yes**	**No**
Do you have end stage renal disease?	**Yes**	**No**

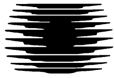
Statement to Permit Payment of
Medicare Benefits to Provider,
Physicians and Patient

Name of Beneficiary ______________________ **Medicare #**______________________

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by or in Iowa Eye Center, including physician services. I authorize any holder of medical or other information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or benefits for related services.

Signature ______________________________ **Date** ______________________

Please complete reverse side



IOWA EYE CENTER

PATIENT NAME ______________________

DATE OF BIRTH ______________________

MEDICAL RECORD # ______________________

PERSONAL EYE HISTORY

YES	NO	CONDITION
____	____	Eye Injury
____	____	Eye Surgery
____	____	Lazy Eye
____	____	Crossed Eyes
____	____	Glaucoma
____	____	Cataract
____	____	Contact Lenses
____	____	Macular Degeneration

FAMILY EYE HISTORY

YES	NO	CONDITION
____	____	Glaucoma
____	____	Cataract
____	____	Blindness
____	____	Crossed/Lazy Eye
____	____	Macular Degeneration

Other: ______________________

PERSONAL MEDICAL HISTORY

YES	NO	CONDITION
____	____	Arthritis
____	____	Asthma
____	____	Bleeding Problem
____	____	Cancer/Tumor
____	____	Diabetes
____	____	Emphysema
____	____	Heart Attack
____	____	Heart Surgery
____	____	Heart Failure
____	____	Hepatitis
____	____	High Blood Pressure
____	____	Kidney Trouble
____	____	Migraines
____	____	Rheumatic Fever
____	____	Thyroid Problems
____	____	Stroke
____	____	Acquired Immune Deficiency Syndrome (AIDS)
____	____	Other:

ALLERGIES TO MEDICATIONS

List all medications you are allergic to:

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____

MEDICATIONS

List all medications you are currently taking.

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PREVIOUS SURGERIES

List any previous surgeries:

____

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MEDICAL HISTORY FORM UPDATED & REVIEWED

DATE:	INITIALS:	DATE:	INITIALS:
________	________	________	________
________	________	________	________
________	________	________	________
________	________	________	________
________	________	________	________
________	________	________	________
________	________	________	________
________	________	________	________