

MECKLENBURG EYE ASSOCIATES, P.A.

PERSONAL INFORMATION - Please Print						
PATIENT NAME <i>(Last, First, Middle Initial)</i>			BIRTH DATE	AGE	SEX M F	MARITAL STATUS M W D S
PATIENT'S ADDRESS <i>(Street, City, State, Zip Code)</i>				HOME PHONE ()		
E-MAIL ADDRESS	CELL PHONE ()	WORK PHONE ()	EXT.	SOCIAL SECURITY NUMBER		
PATIENT'S EMPLOYER				OCCUPATION		
EMPLOYER'S ADDRESS <i>(Street, City, State, Zip Code)</i>						
SPOUSE						
NAME - SPOUSE <i>(Last, First, Middle Initial)</i>			BIRTH DATE	WORK PHONE ()	SOCIAL SECURITY NUMBER	
EMPLOYER	EMPLOYER'S ADDRESS <i>(Street, City, State, Zip Code)</i>					
PARENT OR GUARDIAN INFORMATION (For Minors only)						
NAME - FATHER <i>(If Minor) (Last, First, Middle Initial)</i>			BIRTH DATE	WORK PHONE ()	SOCIAL SECURITY NUMBER	
EMPLOYER	EMPLOYER'S ADDRESS <i>(Street, City, State, Zip Code)</i>					
NAME - MOTHER <i>(If Minor) (Last, First, Middle Initial)</i>			BIRTH DATE	WORK PHONE	SOCIAL SECURITY NUMBER	
EMPLOYER	EMPLOYER'S ADDRESS <i>(Street, City, State, Zip Code)</i>					
EMERGENCY CONTACT						
CONTACT PERSON NOT LIVING WITH YOU			ADDRESS			
RELATIONSHIP	PHONE ()					
WORKMAN'S COMPENSATION						
If Visit Is Covered By Worker's Comp., Please Complete This Section:						
Were You Injured At Work? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, Date of Accident _____						
How Did Injury Occur? _____						
Were You Seen In The Emergency Room? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, Which Hospital? _____						
Person To Contact For Employer Authorization _____						

INSURANCE AUTHORIZATION (Please Read and Sign)

I hereby authorize Mecklenburg Eye Associates, P.A. - James J. Bedrick, M.D., Charles A. Blotnick, M.D., and/or Daniel J. Simon, M.D. - to furnish information to insurance carriers concerning my illness and treatments. ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

I Will Pay For My Visits At The Time Of Service By: CASH CHECK VISA MASTERCARD AMERICAN EXPRESS DISCOVER BANK DEBIT CARD

I understand that I am responsible for all fees regardless of insurance.

Date: _____ Signature: _____ *(Please complete reverse side)*

Referred By: Friend _____ Dr. _____ Yellow Pages/Website/Other: _____

Prior Eye Doctor _____

Primary Medical Doctor _____

Reason For Visit _____

Please list all MEDICATIONS _____
you are currently using _____
including dosage: _____
(include non-prescription & vitamins) _____

Medical History

Yes	No	
		Diabetes for _____ years
		High Blood Pressure for _____ years
		Heart Attack. When?
		Angina or Chest Pain?
		Stroke. When?
		Lung Diseases: Asthma/COPD/Emphysema/Other _____
		GI Problems
		Arthritis Details
		Neurologic Problems
		Endocrine Problems
		AIDS/HIV/Hepatitis C/Other Blood Diseases?
		Other Medical Conditions
		Smoke Approximately _____ Packs Daily

Allergies or Drug Reactions _____ No _____ Yes To: _____

Eye Diseases & Surgery

Yes	No	
		Cataract Surgery. When?
		Glaucoma for _____ years
		Retinal Detachment Surgery. When?
		LASIK/PRK/RK. When?
		Eye Muscle Surgery. When?
		Other Eye Conditions:

Eye Medications: _____

Family History (circle): Diabetes / High Blood Pressure / Glaucoma / Retinal Detachment / Macular Degeneration