COBLE EYECARE with Personal Optics
Mark Coble, O.D. Karen Stephens, O.D. Brian Coble, O.D.

Today's Date _____

Name _____DOB_____Age_____Gender: Male/Female

Street_____City_____State_____Zip_____

Home Phone:_____ Cell Phone _____ Work Phone _____

Preferred Daytime Phone: Home Cell Work Status: Married Single Widowed Other.

We are doing more electronic communications with our patients. This info will not be shared.

email																					

Employer (or School)_____Occupation(or Grade)_____

If a minor under 18: Parent/Guardian name:_____

To file your insurance for you, we must have the following information plus a copy of your card:

PRIMARY INSURANCE COMPANY: _____

Patients Social Security # _____

If the patient is the Primary Policy holder then circle YES and go to Secondary Insurance Co. If not, please fill out the following:

Policy Holders Name_____Relationship to Patient: spouse, parent, stepparent, other _____

Policy Holders SS #_____ Policy holders Status: Married Single Other _____

Policy Holders Date of Birth_____ Male/Female Policy Holders Employer_____

SECONDARY INSURANCE COMPANY: _____

If the patient is the secondary policy holder then circle YES and skip to the following paragraph. If not please fill out the following:

Policy Holders Name_____Relationship to Patient: spouse, parent, stepparent, Other _____

Policy Holders SS #_____ Policy holders Status: Married Single Other _____

Policy Holders Date of Birth_____ Male/Female Policy Holders Employer_____

PLEASE READ AND SIGN BELOW

ALL COPAYS AND COINSURANCE AMOUNTS ARE DUE AT THE TIME OF SERVICES. IF FOR ANY REASON YOUR INSURANCE COMPANY DENIES PAYMENT, THE TOTAL FOR SERVICES AND MATERIALS IS YOUR RESPONSIBILITY. VERIFYING ELIGIBILITY DOES NOT GUARANTEE PAYMENT FROM YOUR INSURANCE COMPANY. ALL COPAYS AND CO-INSURANCE AMOUNTS ARE ESTIMATES AND BALANCE BILLING WILL BE DONE AFTER WE RECEIVE PAYMENT FROM THE INSURANCE COMPANY.

I authorize any medical information about me be released to the appropriate insurance company and its agents along with any other information necessary to process my insurance claim and I accept responsibility for any payment due after insurance has been settled. I acknowledge being offered Coble Eye Associates "Notice of Privacy Practices" dated April 14, 2003.
I also approve the following person or people appropriate to share my results with. 1._____

2._____.

Signature_____

PERSONAL MEDICAL HISTORY

Please Circle yes or no

Cancer	yes	no
Allergies	yes	no
Arthritis	yes	no
Asthma	yes	no
Diabetes	yes	no
Heart Disease	yes	no
High Cholesterol	yes	no
High Blood P.	yes	no
Immune disease	yes	no
Thyroid Disease	yes	no
Nerve Disorder	yes	no
Eye Disease	yes	no
Eye surgery	yes	no
Cataracts	yes	no
Glaucoma	yes	no

Are you pregnant or nursing yes no
Other health issues?

Height _____ Weight _____

Check most appropriate:

Tobacco use:
Never smoked ___
Former smoker ___ Stopped in____(yr)
Packs Per day ___ Started in ____(yr)
Smokeless Tobacco user ____

Alcohol Use:
No use ___
Social Use ___
1-2 drinks/day ___
Alcohol Dependence ___

Narcotic drug use:
None ___
Recreational use ___
Dependence ___

CURRENT MEDICATIONS

Please list all your medications

___I am not taking medications at this time.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Current Primary Care Doctor:

MD's name _____

Phone # _____

Allergies to medications? Please list:
_____
_____
_____
_____

FAMILY MEDICAL HISTORY

If anyone in your family has the following then please provide their relationship to you.

Blindness _____
Cataracts _____
Glaucoma _____
Diabetes _____
Heart disease _____
High Blood Pressure _____
Macular Degeneration_____

Do you experience…

Please check the ones which apply to you

__Burning __Itching
__Distance Blur __Reading Blur
__Light Sensitive __Spots/Floaters
__watering __Redness
__Dryness __Light Flashes
__Mattering __Headaches
__Computer Vision Strain

Are you interested in…

Contacts	Yes	No
Computer Eyewear	Yes	No
Prescription Sunwear	Yes	No
Sports Eyewear	Yes	No
Safety Eyewear	Yes	No
Reading Eyewear	Yes	No

Do you …

Wear Contact lenses? Yes No

Throw them away every?
Day 2 weeks month other

Sleep in your lenses?
Always Occasionally Never

Experience all day comfort?
Always Sometimes Never

Solution Brand _____

Signature: _____ Date: _____

Eye Health & Wellness Screening

We now offer tests which screen eyes for ***Retinal Disease*** and ***Macular Degeneration***. We recommend these as diagnostic and baseline test for everyone over 25 and highly recommend them if there is any history of eye disease in the family. These findings are saved in your record for baseline documentation and future reference. We encourage updating these screenings every 3 years. While your insurance may cover a routine eye examination they do not cover test for screening purposes. The fee for the ***Eye Health & Wellness Screening*** is **$32.00**.

_____Yes, I do want the Eye Health & Wellness Screening _____No Thanks