COBLE EYE CARE & *Optical Gallery*
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 # _____

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: _____

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 INITIAL

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.

INITIAL: _____

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. _____

Initial: _____

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)
Current Smoker ___ Started in ____(yr)

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

Narcotic drug use:
None ___
Recreational use ___
Dependence ___

CURRENT MEDICATIONS

___I am not taking medications at this time.

Please list all your medications

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

Current Primary Care Doctor:

MD's name _____

Phone # _____

Any 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 _____
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

Other Concerns:_____
_____
_____
_____

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 _____

Annual Eye Health & Wellness Screening Photos: $32.00

- A photo of the inside of the eye is taken
- We will view the photo for signs of Glaucoma, Macular Degeneration and other Retinal Disease.
- Insurance does **not** cover the $32.00 fee
- The need for dilation will be determined after viewing the photo.

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

Signature: _____ **Date:** _____