PLEASE FILL OUT ALL OF THE BLANK FIELDS AND PLEASE MAKE SURE TO SIGN EVERY SHEET THAT NEEDS A SIGNATURE. THERE ARE 7 SHEETS OF PAPER WORK TO FILL OUT.

THANK YOU

DR. HEMELT AND DR. FAWER

Originals

NORTHLAKE EYE CENTER
PATIENT INFORMATION

First_____ Last_____ M or F Age_____DOB_____

Address_____ City_____ State_____ Zip_____

Home#_____ Work#_____ Cell#_____ Email_____

Social Sec#_____ Language_____ Marital Status: M S D W Sep Unk

Primary Care Physician_____ Referring Doctor, Person, or Ad_____

Occupation_____ Employment status: FT PT Unemp

Employer_____ Employer Phone_____ Ext_____

Employer Address_____ City_____ State_____ Zip_____

Emergency Contact_____ Relation_____ Phone_____

Race_____ Ethnicity: Latino Non-Latino (You must select one)

INSURANCE INFORMATION We MUST receive a copy of all insurance cards and information at the time of service

PRIMARY INSURANCE_____ ID#_____

Name of Insured_____ Date of Birth_____ Relationship_____

SECONDARY INSURANCE_____ ID#_____

Name of Insured_____ Date of Birth_____ Relationship_____

TERTIARY INSURANCE (3RD INS)_____ ID#_____

Name of Insured_____ Date of Birth_____ Relationship_____

VISION INSURANCE_____ ID#_____

Name of Insured_____ Date of Birth_____ Relationship_____

ARE YOU CURRENTLY ENROLLED IN A HOSPICE PROGRAM? YES NO

Guarantor (if different from above) _____ Relationship_____

Address_____ City_____ State_____ Zip_____

DOB_____ Social Security#_____

IF YOU REQUIRE A REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN, YOU MUST HAVE IT PRIOR TO SEEING THE DOCTOR.WE WILL SUBMIT YOUR CLAIMS USING THE INSURANCE INFORMATION GIVEN ON THE DATE OF SERVICE. YOU MUST INFORM US IF YOU HAVE VSP OR DAVIS VISION. WE CANNOT RESUBMIT CLAIMS THAT HAVE BEEN SUBMITTED TO ANOTHER INSURANCE COMPANY.

Signature_____ Date_____

Family History

	Relationship		Relationship
Macular Degeneration		Cancer	
Cataract		Diabetes	
Glaucoma		Heart Disease	
Ocular Cancer		Hypertension	
Other Ocular		Stroke	
		Sickle Cell	
		Migraines	

Please List Any **EYE MEDICATIONS/ EYE VITAMINS** Currently Taking:

Please List **ALL** Other Prescription Medications Currently Taking:

Please List All Food and Drug Allergies and Their Reaction:

Primary Care Doctor/Rheumatologist/Endocrinologist: _____

Name of Pharmacy: _____

If You Wear Contact Lenses Please Write Down the Brand and Power for Each Eye:

Past Medical History (Please Circle All That Apply)

Diabetes	**Stroke**	**Sickle Cell**	**Epilepsy**
Hypertension	**Cancer- Type:**	**Ulcerative Colitis**	**Nutritional Deficiency**
Heart Disease	_____	**Depression/Anxiety**	**Headaches/Migraines**
Heart Stent or Pacemaker	**HIV/AIDS**	**Skin Condition**	**Hearing Disorder**
Heart Attack	**Hepatitis**	**Lupus**	**Vocal Problem**
High Cholesterol	**Alcoholism**	**Rheumatoid Arthritis**	**Smelling Defect**
Graves' Disease	**Asthma**	**Thyroid Disease**	**Tasting Defect**
Blocked Carotid Artery	**Lyme Disease**	**Organ Transplant**	**Liver Disease**
Temporal Arteritis	**Arthritis**	**Parkinson's**	
Anemia	**Gall Bladder Disease**	**Multiple Sclerosis**	
A-Fib	**GERD**	**Kidney Failure**	
Premature Birth	**Dementia/Alzheimer's**	**COPD**	
Birth Defect	**Sleep Apnea/Machine**	**Myasthenia Gravis**	

Please List any other Medical History and ALL Surgical History:

_____

_____

_____

Do you drink alcohol? Yes No How often? _____

Do you smoke? Yes No Former

When was your last complete eye exam? _____

Past Ocular History (Please Circle All That Apply)

Cataracts	**Iritis/Uveitis**	**Double Vision**	**LASIK**
Surgery? Year_____	**Eye Turns In/Out**	**Dry Eye Syndrome**	Year_____
Glaucoma	Surgery? Year_____	**Retinal Detachment**	**PRK**
Surgery? Year_____	**Facial Palsy**	Eye/Year_____	Year_____
Diabetic Retinopathy	**Eyelid Tumor**	**Retinal Tear**	**RK**
Laser/Surgery?	**Eyelid Cancer**	Eye/Laser?_____	Year_____
Macular Degeneration	**Droopy eyelid**	**Tear Duct Disorder**	**Cosmetic Facial Surgery**
Laser/Injections?	**Cancer in Eye**	**Floaters**	**Corneal Surgery**
Lazy Eye	**Facial Pain**	**Flashes of Light**	Eye/Year_____
Retinal Vein Occlusion	**Conjunctivitis (Pink Eye)**	**Night Blindness**	
(Stroke in the eye)	**Orbital Tumor/Disease**	**Total Blindness**	
Retinal Artery Occlusion	**Optic Neuritis**	**Color Blindness**	
Severe Eye Injury	**Optic Nerve Damage**		