Mack Eye Center
Welcome To Our Office

Welcome to Mack Eye Center. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. If you have any questions, please do not hesitate to ask.

Today's Date: _____

First Name: _____ MI: _____ Last Name: _____ Preferred Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Social Security #: _____/_____/_____ Date of Birth: _____/_____/_____ Sex: _____ Primary Language: _____

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____ Email: _____

Emergency Contact: _____ Relationship: _____ Emergency Phone: _____-_____-_____

Primary Insurance Information

Insurance Co: _____ Identification #: _____ Group#: _____

Name of Insured: _____ Insured Birth Date: _____ Relationship to Insured: _____

Secondary Insurance Information

Insurance Co: _____ Identification #: _____ Group#: _____

Name of Insured: _____ Insured Birth Date: _____ Relationship to Insured: _____

Patient History and Information

Primary Care Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Referring Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Reason for today's visit: _____ last eye exam: _____

Medications

_____

_____

_____

Allergies

_____

_____

_____

Medical History Questionnaire

Disease	Self (Yes or No)	Family member (Yes or No)	Which family member(s)
Amblyopia (Lazy Eye)			
Blindness			
Cancer			
Color Blindness			
Diabetes			
Glaucoma			
High Blood Pressure/Stroke			
Macular Degeneration			
Neurological Disease			
Retinal Disease			
Strabismus (Crossed Eyes)			
Thyroid			

Social History

Do you smoke?	Yes or No	Occasional	½ pack day	1 pack day	1+ pack
Do you drink?	Yes or No	Occasional	1 per day	2-3 per day	4+ day
Do you use Illegal drugs?	Yes or No				

We wish to thank you for completing this form. This will help us in better serving your needs. I acknowledge that the above information is true.

Patient Signature or Legal Guardian: _____ Date: _____

Consent for Release of Confidential Information

Mack Eye Center respects the privacy of every patient and does it best to protect such information. We will however release medical information to another physician when it is necessary for the treatment of our patients. Please know that only pertinent information will be released to ensure that your privacy is maintained.

There are also times when your insurance carrier requires additional health information I order to process payment for claims. In the instances, only the relevant information will be provided to them. Again, we do our best to protect your health information.

I understand that Mack Eye Center has the right to release my health information for the above reasons. I also know that they will protect my information to the best of their ability.

This consent is valid the entire length of my relationship with the Mack Eye Center. Should I feel it is necessary to revoke this notice, I understand it must be done in writing to my physician's office.

Patient Signature or Legal Guardian: _____ Date: _____

More detailed information is available upon request.