Matthew T. Lewis, M.D.
James G. Luetkemeyer, M.D.
Bradley E. Talley, M.D.

CAPITOL EYE CARE

Confidential Patient Information

Patient Name:______________________________ Male / Female Birth date:________ Age:____
First *M.I.* *Last*
*If patient is a child, please list parent's name:*______________________________

Patient Address:____
Street *City* *State* *Zip*

Social Security #:__________ Home Phone #:__________ Work #:__________ Mobile #:__________
Employer: ______________________ Occupation:______________________
Marital Status:______________________ Spouse's name:______________________

Emergency Contact:________________ Relationship:______________________
Home Phone #:________________ Work #:__________ Mobile #:____________

Primary Insurance:____________________ Policy # / ID#:______________________
Secondary Insurance:__________________ Policy # / ID#:______________________

Referring Doctor:____________________ Primary Care Physician:________________

How did you hear about our practice?

____

What are your primary eye concerns today?

____

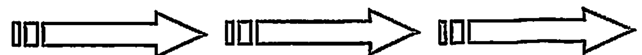
Review of Systems

Family History *(please circle all that apply)*: Diabetes Glaucoma Macular Degeneration Lazy Eye

Please circle any symptoms that you are currently experiencing:

Loss of vision	Weight loss	Shortness of breath	Arthritis	Thyroid abnormalities
Eye pain	Stuffy nose	Upset stomach	Rash	Bleeding
Tearing	Ear ache	Diarrhea	Changing moles	Anemia
Redness	Cough	Constipation	Seizure	Allergies
Headache	Dry mouth	Burning on urination	Stroke	Hay fever
Amaurosis fugax	High blood pressure	Urinary frequency	Paralysis	Hives
Jaw pain	Rapid heart beat	Incontinence	Anxiety	
Scalp tenderness	Congestion	Joint pain	Depression	
Chills	Wheezing	Stiffness	Insomnia	

Please turn over to page 2 for Medical History and Consent for Treatment....



Medical History

Medical Problems / Conditions *Diabetes, please list: Type I / II & controlled / uncontrolled	Surgical History	Eye History / Conditions

Medications:	Medication Allergies:

Social History

Alcohol use: Y / N - Frequency:__________ O History of IV Drug Use: Y / N -Type, if any:__________

Tobacco use: Current Smoker Former Smoker Never Smoked

Do you drive in the daytime? Y / N Do you drive at night? Y / N

Consent for Treatment

The patient/parent who requires treatment is responsible for all fees at the time of service. If we participate with your insurance plan, we will file for you with any co-pay/deductible due at the time of service. If we do not participate with your insurance plan, we will ask for payment in full at the time of service and file your insurance as a courtesy with any reimbursement sent to you.

Consent for treatment: I hereby authorize Capitol Eye Care, Inc., to examine and administer treatment considered therapeutically or diagnostically necessary. I request that payment for authorized benefits under my medical insurance plan be made to the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these or related benefits.

Signature:______________________________ **Date:**__________________