Matthew T. Lewis, MD
James G. Luetkemeyer, MD
Brad E. Talley, MD

CAPITOL
EYE CARE

Confidential Patient Information

Patient Name: _____ Birthdate: _____ Age: _____

If patient is a child, please list the parent's name: _____

Patient Address: _____

Social Security #: _____ Male or Female? (*Circle One*)

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 Symptoms

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	Insomnia
Eye Pain	Stuffy Nose	Upset Stomach	Rash	Bleeding	Stiffness
Tearing	Earache	Diarrhea	Changing Moles	Anemia	Wheezing
Redness	Cough	Constipation	Seizure	Allergies	Chills
Headache	Dry Mouth	Burning on Urination	Stroke	Hay fever	Depression
Amaurosis Fugax	High Blood Pressure	Urinary Frequency	Paralysis	Hives	Joint Pain
Jaw Pain	Rapid Heart Beat	Incontinence	Anxiety	Scalp Tenderness	Congestion

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Medical History

Medical Problems/Conditions	Surgical History	Eye History/Conditions

Medications: Medication Allergies:

Social History

Alcohol Use (*circle one*): Yes / No - Frequency: _____ History of IV Drug Use: Yes / No - Type, if any:_____

Tobacco Use: Current Smoker Former Smoker Never Smoked

Do you drive in the daytime?: Yes / No Do you drive at night?: Yes / No

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: _____

Email Address: _____ May we email you? Yes / No