Thank you for choosing In Focus Eyecare for your eye and vision care.

Legal Name: _____

Preferred Name: _____ **DOB**: _____

Responsible Party: _____**Relationship**: _____
(If other than patient or child is a minor)

Primary Care Doctor: _____

Last Eye Exam: _____

Terms of Service

- I am responsible for presenting complete insurance information to In Focus Eyecare of Rockford prior to receiving services. My signature serves as a "signature on file" for claims processing and for release of medical information to my insurance carrier.
- I am responsible for payment at the time of each visit for all services provided by In Focus Eyecare of Rockford not covered by my medical insurance or vision plan, including copays and deductibles.

In an effort to provide greater confidentiality and to maintain compliance with HIPAA, please review and complete below. **I understand this information may be amended by my request at any time.**

- I hereby give permission to leave a message or text regarding general appointment information, results, and/or vision advice using the preferences indicated below.
- I acknowledge that I was offered and/or received a copy of In Focus Eyecare of Rockford's Notice of Privacy Practices. I understand that I may ask questions about these practices at any time.

  Phone Number: _____

  Address: _____

  Email Address: _____

  Emergency Contact
  Name/Relationship:_____**Phone**:_____

During the COVID-19 pandemic our office is doing everything within our power to ensure a safe environment for both patients and staff with enhanced sanitation & screening protocols.

Please initial if the following is true.

- _____ I have not been tested for or diagnosed with Covid-19 infection.
- _____ I have not had a fever in the last 48 hours.
- _____ I have not had a worsening cough, shortness of breath or flu-like symptoms in the last 48 hours.
- _____ I have not had any chills, muscle pain, sore throat, or a recent loss of taste or smell in the last 48 hours.
- _____ I have not been in close contact with anyone who tested positive for COVID-19 in the last two weeks.

If any of the above are not true, please tell the staff immediately so extra precautions can be taken.

By signing below, I acknowledge that I have read and agree to all items as outlined above.

Signature: _____Date:_____
Patient or Parent (Guardian)

SYMPTOM HISTORY In the past **several days** have you had any of the following symptoms? [All Patients]

☐Y ☐N Constitution . . . . . (fever, aches, chills, lack of appetite, etc)
☐Y ☐N Skin . . . . . (acne, skin cancer, eczema, rosacea, etc)
☐Y ☐N Neurologic . . . . . (headaches, migraines, seizures, muscle weakness, etc)
☐Y ☐N Eyes . . . . . .(blur, blind spot, double, discomfort, discharge, floaters, flashes)
☐Y ☐N Breathing. . . . . .(asthma, emphysema, COPD, etc) .
☐Y ☐N Ears, nose, mouth, throat . . . . . (difficulty hearing, dizzy, pain, dry mouth, congestion, etc)
☐Y ☐N Cardiovascular . . . . . (heart palpitations, high blood pressure, etc)
☐Y ☐N Gastrointestinal . . . . . (stomach pain, reflux, diarrhea, etc)
☐Y ☐N Genito-urinary . . . . (kidney, bladder, prostate, menstruation, etc)
☐Y ☐N Bones, joints, muscles . . . . (arthritis, pain, weakness, swelling, etc)
☐Y ☐N Blood. . . . . .. (bruising, slow wound healing, anemia, etc)
☐Y ☐N Endocrine . . . . . .(excessive thirst, urination, abnormally hot or cold, etc)
☐Y ☐N Allergic, immunologic . . . . (sneezing, runny nose, rash, itchy eyes, etc)
☐Y ☐N Psychiatric . . . . (anxiety, depression, bipolar disorder, etc)

New patients please complete. Returning patients, please indicate any changes.

P**rescription medications**? ☐Yes ☐No List all prescriptions that you are taking or we can copy your list if you have one:

_____
_____
_____
_____

Do you take **over-the-counter medications**? ☐Yes ☐No List those that you are taking:

_____
_____

Are you **allergic to any medications**? ☐Yes ☐No Please list _____

_____
_____

MEDICAL HISTORY Have you ever been diagnosed with or treated for any of the following conditions?

□ Heart Disease	□ High Blood Pressure	□ High Cholesterol
□ Kidney Disease	□ Concussion/TBI	□ Thyroid Disease
□ Arthritis	□ Cancer	□ Diabetes

EYE HISTORY Do you now or have you ever had any of the following eye problems?

□ Blindness	□ Cataracts	□ Glaucoma
□ Crossed Eyes	□ Macular degeneration	□ Retinal Detachment
□ Prominent Eyes	□ Lazy Eye	□ Drooping Eyes
□ Eye Injury	□ Eye Infection	□ Retinal Macular Disease

Do you wear **glasses**? ☐ Yes ☐ No
Do you wear **contacts**? ☐ Yes ☐ No

FAMILY HISTORY Does anyone in your **immediate family** have a history of the following?

☐ Blindness	☐ Retinal Detachment	☐ High Blood Pressure
☐ Cataracts	☐ Arthritis	☐ High Cholesterol
☐ Glaucoma	☐ Cancer	☐ Kidney Disease
☐ Crossed or lazy eyes	☐ Diabetes	☐ Lupus
☐ Macular degeneration	☐ Heart Disease	☐ Thyroid Disease

Do you drive? ☐Yes ☐No Have any difficulty when driving? ☐Yes ☐No

Do you use **Tobacco products?** ☐Yes ☐No **Alcohol?** ☐Yes ☐No **Illegal drugs?** ☐Yes ☐No