Hometown Eye Care
4612 W. Algonquin Rd.
Lake In The Hills, IL 60156
Office (847) 515-2020
Fax (847) 515-2859

PATIENT DEMOGRAPHICS

First Name(NO NICKNAMES):_____MI:_____ Last Name:_____

DOB:_____ SSN:_____ Gender: Male ☐ Female ☐

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

Home Phone:_____ Cell Phone:_____Text OK? Yes ☐ No ☐

Email: _____ Email OK? Yes ☐ No ☐

Marital Status: Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other ☐

Occupation:_____ Employer:_____

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

INSURANCE

Name of **Vision** Insurance:_____ Name of **Medical** Insurance:_____

Vision Member ID:_____ **Medical** Member ID:_____ Group:_____

Relationship to Policy Holder: Self (Skip next questions) ☐ Spouse ☐ Parent/Guardian ☐ Other ☐

Policy Holder's First Name(NO NICKNAMES):_____ Last Name:_____

DOB:_____ SSN:_____ Gender: Male ☐ Female ☐

Occupation:_____ Employer:_____

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

HIPAA AND INSURANCE RELEASE

I acknowledge that I have had the chance to review the Notice of Privacy Practices and upon request may have a copy. The patient's portion is to be paid at the time services are rendered unless other arrangements are made in advance. The undersigned will be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees in addition to the account balance due. There will be a service charge on all returned checks. Professional services are not refundable and all product sales are final. Any returns that are approved may be subject to a restocking fee. I authorize payment from my insurance to be paid directly to Hometown Eye Care. I understand that billing any out of network insurance will be my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed. I authorize the use of this form on all insurance submissions and the release of all information to my insurance companies. I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies. I permit a copy of this authorization to be used in place of the original.

PATIENT SIGNATURE/ PARENT OR LEGAL GUARDIAN: _____

MEDICAL HISTORY

PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING CONDITIONS:

Developmental Disabilities ☐
Cancer ☐
Fatigue Syndrome ☐
Hearing Loss ☐
Sinusitis ☐
Dry Mouth ☐
Laryngitis ☐
Multiple Sclerosis ☐
Epilepsy ☐
Cerebral Palsy ☐
Tumor ☐
Stroke/CVA ☐
Migraine ☐
Autism Spectrum Disorder ☐
Depression ☐
Attention Deficit ☐
Anxiety Disorder ☐
Bipolar Disorder ☐
Hypertension ☐
Heart Disease ☐
Vascular Disease ☐
Congest Heart Failure ☐
Cigarette Smoker ☐
Asthma ☐
Emphysema ☐
Chronic Obstruction ☐
Sleep Apnea ☐

Crohn's ☐
Colitis ☐
Ulcer ☐
Acid Reflux ☐
Celiac Disease ☐
Kidney Disease ☐
Prostate Disease/Cancer ☐
STD ☐
Benign Prostate ☐
Nursing ☐
Herpes ☐
Chlamydia ☐
Osteoarthritis ☐
Arthritis ☐
Fibromyalgia ☐
Muscular Dystrophy ☐
Ankylosing Spondylitis ☐
Osteoporosis ☐
Gout ☐
Eczema ☐
Rosacea ☐
Psoriasis ☐
Herpes Simplex/Cold Sores ☐
Herpes Zoster/Shingles ☐
Type 2 Diabetes ☐
Type 1 Diabetes ☐
Thyroid Dysfunction ☐

Hormonal Dysfunction ☐
Anemia ☐
Large-volume blood loss ☐
High Cholesterol ☐
Drug Allergies ☐
Environmental Allergies ☐
Rheumatoid Arthritis ☐
Lupus ☐
Sjogren's Syndrome ☐
Other(list other below) ☐

_____

Tobacco Use

Never ☐
Former Smoker ☐
Current Everyday Smoker ☐
Current Someday Smoker ☐

Alcohol Use

None ☐
Socially ☐
1-2 Drinks Daily ☐
1-2 Drinks Weekly ☐

Medications:(Prescriptions, drops, sprays, inhalers, creams, vitamins, and over the counter)

LIST NAME AND DOSAGE

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies:(Medications and environmental)

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

EYE HISTORY

CHECK IF YOU HAVE ANY OF THE FOLLOWING PROBLEMS:

Cataracts ☐
Macular Degeneration ☐
Glucoma ☐
Diabetic Retnopathy ☐
Dry Eye ☐
Eye Infection ☐
Floaters ☐
Flashes ☐
Iritis ☐
Uveitis ☐
Redness ☐
Burning ☐
Itching ☐
Tearing ☐
Discharge ☐
Blurred Vision ☐
Eye Strain ☐
Eye Pain ☐
Severe Sensitivity to Lights ☐
Headaches ☐
Poor Night Vision ☐
Night Glare ☐
Double Vision ☐
Total Vision Loss ☐

Do you wear **contact lenses**?
Yes ☐ No ☐
If **yes**, what brand?

_____

If **no**, are you interested?
Yes ☐ No ☐

Do you wear **glasses**?
Yes ☐ No ☐

Do you use computers or devices for extended periods?
Yes ☐ No ☐
If **yes**, how many hours per day?

_____

RATE YOUR VISION BASED OFF WHAT YOU NORMALLY WEAR MOST DAYS

Distance Vision:
Glasses ☐ Contacts ☐ No Correction ☐

Acceptable ☐ Needs Improvement ☐ Blurred ☐

Near Vision:
Glasses ☐ Contacts ☐ No Correction ☐

Acceptable ☐ Needs Improvement ☐ Blurred ☐

Computer/Intermediate Vision:
Glasses ☐ Contacts ☐ No Correction ☐

Acceptable ☐ Needs Improvement ☐ Blurred ☐

ADDITIONAL TESTS OFFERED

- **Optos Retinal Imaging**

The digital imaging of the internal eye without the need for dilation. This test documents the current condition of the optic nerve, macula, and retina and helps to diagnose various medical conditions, including but not limited to, Macular Degeneration, Diabetes and High blood pressure.

- **Visual Fields**

Maps the peripheral vision. Peripheral vision changes are caused by the development of various medical conditions, including but not limited to, Glaucoma, Tumors, Stroke, Aneurysms and High blood pressure. Most patients do not notice peripheral vision changes.

- **MPOD**

The leading cause of vision loss in patients over the age of 55 is Macular Degeneration. Over a lifetime of diet and UV exposure the pigment in the back of the eye can be affected. Pigment scores can be improved with special nutritional counseling and lens protection treatments. Smokers have a 110 times higher risk for Macular Degeneration.

- **OCT (Optical Coherence Tomography)**

Like an ultrasound for the eye, this test uses light to scan the retina and optic nerve. The results look like an MRI image and allows for early detection of Glaucoma and Retinal problems, as well as monitor for changes that can be caused by some medications.

Patients **18 and over** please choose one:

I WOULD LIKE TO DO ALL **4** TEST FOR AN ADDITIONAL **$68** TODAY ☐

I WOULD LIKE TO **DECLINE**. I AM AWARE OF THE BENEFITS AND RISKS IN EARLY DETECTION OF DISEASES, TUMORS AND OTHER RELATED DISORDERS ☐

I WOULD LIKE TO HAVE **ONLY THE TESTS I'VE CHECKED BELOW** AT THIS TIME ☐

OPTOS RETINAL IMAGING $36 ☐
VISUAL FIELDS $11 ☐
MPOD $14 ☐
OCT $97 ☐

Patients **17 and under** please choose one:

I WOULD LIKE TO DO **OPTOS RETINAL IMAGING** FOR AN ADDITIONAL **$36** TODAY ☐

I WOULD LIKE TO **DECLINE**. I AM AWARE OF THE BENEFITS AND RISKS IN EARLY DETECTION OF DISEASES, TUMORS AND OTHER RELATED DISORDERS ☐