CHICAGO EYE INSTITUTE

Preferred Language:
☐ English ☐ Polish
☐ Spanish ☐ Ukrainian

Location:
☐ MIL ☐ ILMC
☐ MER ☐ STE
☐ PUL

Date: _____

Staff: _____

CEI ID# ☐

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ SSN: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Gender: ☐ Male ☐ Female

Race: _____ Latino/Hispanic? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow/er ☐ Other

INSURANCE INFORMATION

Insurance Company: _____

Insured Name: _____

Relationship to Insured:
☐ Husband
☐ Wife
☐ Self
☐ Other

Insured Date of Birth: _____

Insured SSN: _____

Employer: _____ Employer Phone: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____

Person Responsible for Bill (if other than patient, or if patient ia a minor):

Name: _____ Relationship: ☐ Husband ☐ Wife ☐ Other

Address: _____

City: _____ State: _____ Zip Code: _____

In Case of Emergency Notify: _____

Relationship: _____ Phone: _____

I hereby consent to the use and disclosure of my health information for treatment provided to me by the Chicago Eye Institute ("Provider") or other health care providers, payment for services provided by Provider or other health care providers, and the operations of the Provider and others under certain circumstances. I understand that a more detailed explanation of the ways Provider may use and disclose my health information is contained in the Notice of Privacy Practices. A copy has been provided to me.

_____

Signature of Patient or Personal Representative Date

Patient name:_____ CEI ID:_____

REVIEW OF SYSTEMS

Primary Physician: _____ Phone: _____

Physician Address: _____

Preferred Pharmacy: _____ Address: _____

_____

List Allergies to Medications: _____

_____

List All Current Medications and Eyedrops:

1- _____ 4- _____

2- _____ 5- _____

3- _____ 6- _____

Are You Diabetic? Yes No

Year Diagnosed: _____

Last HgbA1c: _____

Last Fasting Blood Sugar: _____

SOCIAL HISTORY

Smoker: ☐ Current ☐ Former ☐ Never

If former smoker, quit date: _____

If current, packs per day: _____ How long? _____

Do You Drink? ☐ > 3/day ☐ 1-2/day ☐ None

FAMILY MEDICAL HISTORY

	Family Member		Family Member
Diabetes		Hypertension	
Cancer		Thyroid Disorder	
Macular Degeneration		Blindness	
Glaucoma		Cataract	
Retinal Detachment		Other	

HAVE YOU EVER HAD ANY PROBLEMS WITH THE FOLLOWING? ANSWER YES OR NO.

	YES	NO		YES	NO
Loss of Vision	☐	☐	Jaundice	☐	☐
Blurred Vision	☐	☐	Frequent Urination	☐	☐
Peripheral Vision Loss	☐	☐	Joint Pain	☐	☐
Double Vision	☐	☐	Lower Back Pain/Stiffness	☐	☐
Eye Pain	☐	☐	Changing Moles	☐	☐
Foreign Body Sensation	☐	☐	Rash	☐	☐
Tearing	☐	☐	Unusual Headaches	☐	☐
Fever	☐	☐	Paralysis	☐	☐
Weight Loss	☐	☐	Memory Loss	☐	☐
Dry Mouth	☐	☐	Anxiety	☐	☐
Sinus Problems	☐	☐	Depression	☐	☐
High Blood Pressure	☐	☐	Excessive Thirst	☐	☐
Irregular Heartbeat	☐	☐	Change in Hair or Skin	☐	☐
Heart Murmur	☐	☐	Bleeding Disorder	☐	☐
Wheezing	☐	☐	Anemia	☐	☐
Difficulty breathing	☐	☐	Seasonal Allergies	☐	☐
Heartburn	☐	☐	Latex Allergy	☐	☐

Above reviewed and appropriate changes made by: _____ Physician _____ date

SELF PAY

Uninsured patients are required to pay a starting charge of $75.00 upon check-in for their appointment. At the end of their visit, based on the level of care received, an additional fee will charged. All self-pay/uninsured fees are based on Medicare rates for that year.

REFUNDS

Patient/guarantor credits will be applied to your account if there is an outstanding balance due. Otherwise, refunds will be refunded to patients/guarantors within 30 business days.

MISSED APPOINTMENTS/LATE CANCELLATIONS

Missed appointments and late cancellations represent a cost to us and other patients who could have benefited from the time slot set aside for you. Cancellations are requested at least 24 hours in advance to your appointment. We reserve the right to charge $50.00 for each missed or late-canceled appointments. Habitual missed or late-canceled appointments may result in discharge from the practice.

I, _____ have read and understand the Chicago Eye Institute Financial Policy. I agree to assign benefits to the Chicago Eye Institute whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collection.

_____ _____

Signature of Insured or Authorized Representative Date