Levin Eye Care Center, P.C.
1334 119th Street
Whiting, IN 46394
(219)659-3050 or (708)868-3050
FAX (219)659-3053

Please have your medical and vision insurance cards available.

Patient Registration

Please Fill Out All Pages **Date:_____**

Patient Name				Salutation	
Date of Birth		Age		Birth State	
Sex				SS #	
Address					
Address Type				Country	

Communication					
Preference					
Home Phone #		Work Phone #		Extension	
Cell Phone #		Email			

Information			
Plan Type		HIPAA Signed	
Primary Language		Ethnicity	
Race		Marital Status	
Occupation		Employer	

Account Responsible					
Responsible				Salutation	
Relationship				SS #	
Address					
Home Phone #		Work Phone #		Extension	
Email					

Primary Insurance			
Name		Group Name	
ID #		Group #	
Address			
Phone		PAY %	
Insured		Date of Birth	
Copay			

Secondary Insurance			
Name		Group Name	
ID #		Group #	
Address			
Phone		PAY %	
Insured		Date of Birth	

Emergency Contact										
Sal	**First**	**Middle**	**Last**	**Relation**	**Home#**	**Cell#**	**Work#**	**Ext**	**Organization**	**Title**

Patient Health History

Please review, make necessary changes and supply any missing information

Current Health Issues:

☐ Diabetes Type 1 or 2

☐ Hypertension

☐ High Cholesterol

☐ Heart Condition / Please Specify _____

☐ Other Medical Condition _____

☐ Thyroid Disorder

Patient Name:		**Date of Birth:**	
Primary Care Physician			
Reason for Last Visit		**How long since your last visit?**	
Last Eye Doctor		**How long since your last eye exam?**	

Date of Last Menstrual Period		**Pregnancy Due Date**	

Last Recorded Diabetic Test			
Date	**SMBS or HgbA1c**	**Value**	**Location /Timing** (Fasting, Post Breakfast, Post Lunch, Post Dinner)

Surgical History		
Date	**Procedure / Surgeon**	**Complications**

Personal Medical History		
Medical Condition / Additional Details	**Age Began**	**Year From – Year To**
Ocular History		
Ocular Condition / Additional Details	**Age Began**	**Year From – Year To**
Social History		
Description / Additional Details List your social history and detail (exercise, drug and alcohol use):	**Age Began**	**Year From – Year To**

Social History		
Description / Additional Details List your social history and detail (exercise, drug and alcohol use):	**Age Began**	**Year From – Year To**

Tobacco Status / History		
Current Tobacco Status	**Age Began**	**Year From – Year To**

Select your tobacco status below if the above status is blank or incorrect:

- ☐ Current everyday smoker
- ☐ Light cigarette smoker (1-9 cigs/day)
- ☐ Current some day smoke
- ☐ Never smoker
- ☐ Former smoker
- ☐ Heavy tobacco smoker

Other Personal Information			
Occupation			
Do you work on a computer?		**Hours per day**	
Work status / duties			
Hobbies			

Family Medical History			
Family Member	**Medical Condition / Additional Details**	**Age Began**	**Year From – Year To**

Allergies			
Allergy	**Onset Date**	**Reaction**	**Severity**

Medications			
Cross out any medications that you are no longer taking and list all prescriptions, over the counter and herbal medications			
Date	**Name**	**Strength**	**Directions**

Contact Lens History					
Type of contact lenses you currently use (gas permeable, soft daily, extended)			**How often do you replace your contacts?** (daily, weekly, monthly)		
Average number of hours that you wear your contacts		**Number of hours worn today**		**Wearing Type** (daily, extended)	Extended wear

PreTesting Questionnaire

Please Circle Answer:

Type of Examination: Eye Exam Contact Lens Exam Office Call

Family History of Glaucoma? Yes / No Family History of Macular Degeneration? Yes / No

Do you wear prescription sunglasses? Yes / No

How many hours a day are you on the computer? _____

Do you have any of the following symptoms? Check all that apply.

Please circle	Never	Sometimes	Often
Blurred vision at distance / Near			
Eyestrain during computer work			
Headaches			
Light Sensitivity			
Eye Pain			
Difficulty driving at night			
Flashes or Floaters			
Itchy Eyes / Watery Eyes			
Red Eyes / Dry Eyes			
Discharge			
Bump on eyelid			
Redness of Eyelid			

Tell us More about your symptoms...

Which Eye? When did this start? How long does it last? Does anything seem to help?

How were you referred to our office?

□VSP Insurance / or Other Insurance

□Family or friend (name): _____

□Another doctor (name): _____

□Internet / Advertisement / Social Media

□Other (please explain): _____

□ Knew about the office / Previous Patient – Several years ago

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eye care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor or ophthalmic group insurance benefits otherwise payable to me. I understand that my eye care insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all fees rendered on my behalf or my dependents at time of service. All fees not paid within 60 days will be transferred to an outside collection agency and a transfer fee of $50.00 will be applied to all transferred accounts.

X

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