Patient Information

First Name (Legal)________________________M.I.________ Last Name________________________________

Name you go by ____________________ M / F Birthdate____________________ SSN_________-_______-____________

Primary Phone # (_______)_______-___________cell / hm / wk Secondary Phone # (_______)_______-____________cell / hm / wk

E-mail____

Street Address____ City ____________________ State_____ Zip___________

Patient Occupation ____________________________Patient Employer____

Circle Marital Status: S M Sep D W Who may we thank for referring you?____________________________

Medical Doctor________________________Phone # (_______)_______-__________Last Medical Exam _____/_____/________

Endocrinologist ________________________Phone # (_______)_______-__________Last Eye Exam_____/______/___________

Pharmacy Name and Location____

Insurance Information

Routine Vision Insurance (You must show your card at each routine visit.)

Name of Insurance______________________________ Policy Holder SSN____________________________

Name of Policy Holder ___________________________ Policy Holder Birthdate ________________________

Primary Medical Insurance (You must show your card at each medical visit.)

Name of Insurance ______________________________ Policy Holder SSN ____________________________

Name of Policy Holder ___________________________ Policy Holder Birthdate ________________________

Secondary Medical Insurance (You must show your card at each medical visit.)

Name of Insurance ______________________________ Policy Holder SSN ____________________________

Name of Policy Holder ___________________________ Policy Holder Birthdate ________________________

Authorization to Release Information

List people we may release information to on your behalf.

Name ______________________________Relationship__________________Phone # (______) _______-___________

Name ______________________________Relationship__________________Phone # (______) _______-___________

Name ______________________________Relationship__________________Phone # (______) _______-___________

Turn paper over and fill out the backside.

Health History

Eye History

I currently wear (circle all that apply): Eyeglasses: Contact Lenses:
Brand:____________________

I have problems when reading? Y / N driving? Y / N

Have you ever had any of the following eye conditions? (Circle all that apply)

Glaucoma	Flashes of Light in Eye(s)	Dryness
Macular Degeneration	Floating Dark Spot in Eye(s)	Sandy/Gritty Sensation
Cataracts	Excess Tearing	Discharge
Retinal Tear/Detachment	Halos	Crusting on Eyelid
Eye Pain	Light Sensitivity	Drooping Eyelid
Blurred Vision	Redness	Other ________________________
Double Vision	Itching	

Social History

Do you use (Circle appropriate answer):

Alcohol: Never / Rarely / Moderate / Daily

Tobacco: Never / Past Smoker / Current - packs/day____________

Illegal drugs: No / Yes - type/frequency____________

Have you been exposed or infected with: Gonorrhea / Hepatitis / HIV / Syphilis / None

Medical History

List any prescription/non prescription eyedrops you are using :____

List all medications you are taking:____

Latex allergy Y / N

Drug allergies Y/ N Please list____

Have you ever had any problems in any of the following areas (Circle all that apply):

Weight Loss/Gain	Fever	Skin Rashes	Headaches	Migraines
Seizures	Thyroid	Allergies/Hay Fever	Sinus	Runny Nose
Post-Nasal Drip	Cough	Dry Throat/Mouth	Asthma	Chronic Bronchitis
Emphysema	Diabetes	Heart Pain	High Blood Pressure	Vascular Disease
High/Low Cholesterol	Diarrhea	Constipation	Genitals	Kidney
Bladder	Rheumatoid Arthritis	Muscle Pain	Joint Pain	Anemia
Bleeding Problems	Allergies/Immunologic	Psychiatric		

Family History

List all family members (ie: sibling, parent, grandparent and great-grandparent) beside the health condition they were diagnosed with:

Blindness	____________	Macular Degeneration	____________	Glaucoma	____________
Crossed Eyes	____________	Retinal Detachment/Disease	____________	Cancer	____________
Heart Disease	____________	Kidney Disease	____________	Arthritis	____________
Diabetes	____________	High Blood Pressure	____________	Lupus	____________
Cataract	____________	Thyroid Disease	____________		

By signing and/or initialing this paper, I am stating everything is true and correct to the best of my knowledge. I am also authorizing the release of any information concerning my health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also authorize payment of insurance benefits otherwise payable directly to the doctor. I also have received or have access to the HIPPA and Privacy Laws.

X____ Date ______/______/__________

Initial_______ Date____/_____/________ Initial________ Date ____/_____/________ Initial_______ Date _____/_____/________