



Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

SS# \_\_\_\_\_ Sex: M F Marital Status: S M W D

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Daytime Phone \_\_\_\_\_ ext \_\_\_\_\_ Home Phone \_\_\_\_\_

Email Address: \_\_\_\_\_

Responsible Party if other than patient \_\_\_\_\_

Address: \_\_\_\_\_

Primary Insurance \_\_\_\_\_ Secondary Insurance \_\_\_\_\_

\_\_\_\_\_

ID# \_\_\_\_\_ ID# \_\_\_\_\_

GROUP#: \_\_\_\_\_ GROUP# \_\_\_\_\_

Name of Insured \_\_\_\_\_ Name of Insured \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Employer Name: \_\_\_\_\_

If you are a new patient how were you referred: \_\_\_\_\_

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.** You will be required to pay your co-pay at each visit.
2. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



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## PATIENT HISTORY INFORMATION

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Name: \_\_\_\_\_ Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Eye Doctor: \_\_\_\_\_ Referring Doctor: \_\_\_\_\_

**Please answer the following questions about your medical status and history.**

**Have you ever been treated for any of the following medical conditions? Please check yes or no and circle all that apply. Explain further in the space provided if necessary.**

Yes No Arthritis (rheumatoid, osteo-degenerative) \_\_\_\_\_

Yes No Blood Diseases (anemia, leukemia, clotting) \_\_\_\_\_

Yes No Ear, Nose, Throat (hearing loss, sinus disease) \_\_\_\_\_

Yes No Diabetes (type, how controlled & when diagnosed) \_\_\_\_\_

Yes No Thyroid Disease (hypo, hyper, Graves disease) \_\_\_\_\_

Yes No Lung Disease (asthma, emphysema, COPD, chronic bronchitis) \_\_\_\_\_

Yes No Heart Disease (heart attack, angina, arrhythmia, heart failure, heart valve disease, bypass surgery) \_\_\_\_\_

Yes No High Blood Pressure \_\_\_\_\_

Yes No Gastrointestinal Disease (ulcers, esophageal reflux, intestinal or liver disease) \_\_\_\_\_

Yes No Genito-Urinary Disease (kidney disease, dialysis, kidney stones) \_\_\_\_\_

Yes No Skin Diseases (eczema, psoriasis, acne, rosacea) \_\_\_\_\_

Yes No Mental Health (depression, anxiety, schizophrenia, bipolar) \_\_\_\_\_

Yes No Cancer (list type or location and date) \_\_\_\_\_

Yes No Infectious Disease (TB, syphilis, gonorrhea, AIDS, HIV, hepatitis) \_\_\_\_\_

Other Problems \_\_\_\_\_

Previous surgery (date/reason) \_\_\_\_\_

**REVIEW OF SYSTEMS** Do you currently have any of the following problems? Please check all that apply.

Yes No Joint pain (musculoskeletal)

Yes No Easy bruising (Hematological)

Yes No High Blood Pressure

Yes No Abnormal thyroid level

Yes No Shortness of breath, wheezing coughing, (Respiratory)

Yes No Chest Pain, palpitations

Yes No Sore throat, ear pain, sinus problems

Yes No Heartburn, abdominal pain, diarrhea, vomiting.

Yes No Pain with urination, blood in urine

Yes No Weakness, numbness, headache

Yes No Rashes, excessive dryness

Yes No Depression/anxiety

**Please list all medications you take (including over the counter medications, or specify if none are taken):** \_\_\_\_\_  
\_\_\_\_\_

**Please list any allergies and reactions you have (including medications, food, or other)** \_\_\_\_\_  
\_\_\_\_\_

**EYE DISEASE**

Have you ever had any eye disease? If yes, please explain and include the year diagnosed.

- Yes  No Cataract \_\_\_\_\_
- Yes  No Corneal Disease or Transplant \_\_\_\_\_
- Yes  No Diabetic Eye Disease \_\_\_\_\_
- Yes  No Glaucoma \_\_\_\_\_
- Yes  No Lazy Eye (Amblyopia) \_\_\_\_\_
- Yes  No Macular Degeneration \_\_\_\_\_
- Yes  No Retinal Detachment or Hole \_\_\_\_\_
- Yes  No Injury \_\_\_\_\_
- Yes  No Surgery or Laser \_\_\_\_\_
- Other \_\_\_\_\_
- Comments \_\_\_\_\_

**FAMILY HISTORY OF DISEASE**

Do you have a family history of any of the following? Please indicate which relative is affected: (example mother, father, sister, or brother)

- Yes  No Cancer \_\_\_\_\_
- Yes  No Diabetes \_\_\_\_\_
- Yes  No Glaucoma \_\_\_\_\_
- Yes  No Heart Disease \_\_\_\_\_
- Yes  No Retinal Disease \_\_\_\_\_

**SOCIAL HISTORY**

- What is your marital status?  Single  Married  Divorced/Widowed
- Do you live alone?  Yes  No  Nursing Home
- Do you smoke?  Yes  No If yes, how much? \_\_\_\_\_
- Do you drink alcohol?  Yes  No If yes, how much? \_\_\_\_\_
- Are you employed?  Yes  No Please list occupation \_\_\_\_\_
- Females, are you pregnant?  Yes  No Breast feeding?  Yes  No

**What is the reason for your visit?** \_\_\_\_\_

**When was your last eye exam?** \_\_\_\_\_

**Patient Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Tech Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Reviewed by Dr.:** \_\_\_\_\_ **Date:** \_\_\_\_\_