

PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information. **Please print!**

All information will be confidential.

Patient Name: _____

(First) (MI) (Last) Date

Reason For Visit : Routine Exam Glasses Contacts Other _____

Social Security Number _____ - _____ - _____ Male Female Birth Date: _____

Home Phone: _____ Daytime/Cell phone: _____

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

E-Mail address: _____

Is Patient (check all that apply): Minor Single Married Divorced Widowed Separated

Unemployed Retired Employed: Full-time Part-time Student: Full-time Part-time

Patient's or parent's employer: _____ Occupation: _____

Work phone: _____ Business address: _____ City: _____ State: _____ Zip: _____

Spouse or parents' name: _____ Employer: _____

Occupation: _____ Work phone: _____

If patient is a student, name of school/college: _____ City: _____ St: _____

Person to contact in case of emergency: _____ Phone: _____

Person Responsible for Account

- **Although our office ensures that we optimize your insurance benefits, we are not responsible for what your insurance covers and does not cover.**

Name of person responsible for this account: _____ Relationship to patient: _____

Is this person currently a patient in our office? Yes No Home ph: _____ Day/cell ph: _____

Social Security Number _____ - _____ - _____ Male Female Birth date: _____

Employer: _____ Work phone: _____

All payments are due on the same day services are rendered. **Guarantor signature:** _____

AUTHORIZATION & RELEASE: I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. Please give a 24 hour notice to cancel or reschedule your appointment. Patient can incur a \$50 fee for a no call no show to their appointment.

Signature: _____ Date: _____ (Please turn over & complete the other side)

Circle all that apply:

I currently wear: Glasses Contacts Both

I am currently experiencing:

I have trouble with:

Ocular Symptoms:

I have or have had:

Dry eyes	Distance (Long range)	Eye Fatigue	Glaucoma
Visual Headaches	Reading (Near Vision)	Pain	Macular degeneration
Ocular fatigue	Computer (Mid range)	Pressure feeling	Cataracts
Squinting	Trouble experienced:	Burning	Amblyopia (lazy eye)
Poor depth perception	With glasses/contacts on? Yes / No	Sandy or gritty	Strabismus (eye turn)
Halos		Other: _____	Other: _____

List all **EYE** surgeries you have had: _____ Date of surgery(s): _____

Review of Systems: Please indicate if you currently experience or have ever experienced any of the following:

All the following information relates to your vision and eye health. **This information is kept strictly confidential.**

Constitutional Symptoms:
 Recent Fever..... No Yes
 Recent Fatigue..... No Yes

Ear/Nose/Throat/Mouth:
 Hearing Loss..... No Yes
 Nose Bleeds..... No Yes
 Sore Throat..... No Yes
 Mouth Sores..... No Yes
 Sinusitis.... No Yes

Neurological:
 Headaches..... No Yes
 Head or neck injury No Yes
 Paralysis..... No Yes
 Fainting No Yes
 Seizure Disorder... No Yes
 Tremors..... No Yes
 Numbness/Tingling
 Sensation..... No Yes

Endocrine:
 Diabetes..... No Yes
 Thyroid Problems... No Yes

Respiratory:
 Shortness Of Breath No Yes
 Wheezing..... No Yes
 Spitting Up Blood No Yes
 Asthma... No Yes
 COPD.... No Yes
 Bronchitis... No Yes

Gastrointestinal:
 Loss of appetite... No Yes
 Nausea and Vomiting No Yes

Psychiatric/Mental:
 Memory loss or
 Confusion..... No Yes
 Depression..... No Yes
 Other psychiatric
 Problems..... No Yes

Cardiovascular/Heart:
 High blood pressure No Yes
 High cholesterol.... No Yes
 Heart Attack or
 Disease..... No Yes
 Chest pain..... No Yes
 Stroke..... No Yes
 Swollen feet, ankles
 Or hands..... No Yes

Integumentary/Skin:
 Skin problems: _____

Genitourinary/Bladder:
 Genital/urinary or
 Bladder problems.. No Yes

Hematologic/Lymphatic:
 Anemia..... No Yes
 Bleeding or
 Bruising tendency.. No Yes
 Slow to heal
 After cut..... No Yes

Musculoskeletal:
 Joint stiffness or
 Swelling..... No Yes
 Muscle pain or
 Cramps..... No Yes
 Back Pain..... No Yes
 Cold extremities.. No Yes

Allergic/Immunologic
 Pollens..... No Yes
 Penicillin or
 Other antibiotics.. No Yes
 Vicodin or
 Other narcotics.. No Yes
 Novocain or
 Other anesthetics.. No Yes
 List allergies to drugs: _____

Other health problems: _____ Are you pregnant or nursing? Yes No

Medical Doctor: _____ Date of last eye examination: _____ Location: _____

Previous hospitalizations and surgeries: _____

Medications: (Include Non-Prescription, vitamins, and eye drops): _____

Family Medical History	Age	Medical/Eye Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Spouse	_____	_____	_____

Do you drive? Yes No If yes, do you have difficulty when driving? Yes No If yes, please describe: _____

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis

Use of Alcohol: Never Rarely Moderately Daily

Use of Tobacco: Never Previously, but not in the past _____ year(s) Currently, and _____ packs/day

Other substances (prescribed or unprescribed): _____