

PATIENT INFORMATION FORM

Patient Account # _____ Date of Birth: _____

Name: _____ Age: _____ Sex: _____ Marital Status: _____

Phone: Home: (____) _____ Work: (____) _____ Cell: (____) _____ SSN #: _____

Home Address: _____ City: _____ Zip Code: _____

Primary Care Physician: _____ Referring Physician: _____

Patient E-Mail: _____ Patient/Parent Employer: _____

Emergency Contact (Name/Phone): _____ Spouse/Parent Name: _____

Primary Insurance Company: _____ Secondary Insurance Company: _____

ID#/Group #: _____ ID#/Group #: _____

Subscriber Name/DOB: _____ Subscriber Name/DOB: _____

PATIENT HEALTH INFORMATION/HEALTH HISTORY

CURRENT MEDICATIONS:

DO YOU HAVE ANY ALLERGIES TO ANY MEDICATIONS? YES NO KNOWN ALLERGIES

IF YES: Medication(s): _____ Reaction(s): _____

Do you have an allergy/sensitivity to: LATEX? YES NO ADHESIVE/TAPE? YES NO

PLEASE LIST ANY RECENT SURGERIES OR HOSPITALIZATIONS: Date: _____ Reason: _____

Date: _____ Reason: _____ Date: _____ Reason: _____

Do you currently wear glasses? <input type="checkbox"/> YES <input type="checkbox"/> NO	Glaucoma: <input type="checkbox"/> YES <input type="checkbox"/> NO	Eye Injury/Surgery: <input type="checkbox"/> YES <input type="checkbox"/> NO
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Amblyopia ("lazy eye") <input type="checkbox"/> YES <input type="checkbox"/> NO	Cataract: <input type="checkbox"/> YES <input type="checkbox"/> NO	Macular Degeneration: <input type="checkbox"/> YES <input type="checkbox"/> NO
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Strabismus (eye wander/cross): <input type="checkbox"/> YES <input type="checkbox"/> NO	Dry Eye: <input type="checkbox"/> YES <input type="checkbox"/> NO	Other:
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High Blood Pressure: <input type="checkbox"/> YES <input type="checkbox"/> NO	Stroke: <input type="checkbox"/> YES <input type="checkbox"/> NO	Tobacco User: <input type="checkbox"/> PAST <input type="checkbox"/> CURRENT <input type="checkbox"/> NEVER
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High Cholesterol: <input type="checkbox"/> YES <input type="checkbox"/> NO	Anxiety/Depression: <input type="checkbox"/> YES <input type="checkbox"/> NO	Cancer: <input type="checkbox"/> YES (Type: _____) <input type="checkbox"/> NO
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Heart Disease: <input type="checkbox"/> YES <input type="checkbox"/> NO	Thyroid Disease: <input type="checkbox"/> YES <input type="checkbox"/> NO	Arthritis: <input type="checkbox"/> YES (Type: _____) <input type="checkbox"/> NO
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Diabetes: <input type="checkbox"/> YES <input type="checkbox"/> NO	Allergies: <input type="checkbox"/> YES <input type="checkbox"/> NO	Other:
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FLU SHOT? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, YEAR? _____	PNEUMONIA VACCINE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, YEAR? _____
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FAMILY OCULAR/MEDICAL HEALTH HISTORY (leave blank if Unknown)

Diabetes <input type="checkbox"/> YES <input type="checkbox"/> NO	Glaucoma: <input type="checkbox"/> YES <input type="checkbox"/> NO	Mac Degeneration: <input type="checkbox"/> YES <input type="checkbox"/> NO	Heart Disease: <input type="checkbox"/> YES <input type="checkbox"/> NO
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Amblyopia <input type="checkbox"/> YES <input type="checkbox"/> NO	Cancer: <input type="checkbox"/> YES <input type="checkbox"/> NO	High Cholesterol: <input type="checkbox"/> YES <input type="checkbox"/> NO	Thyroid Disease: <input type="checkbox"/> YES <input type="checkbox"/> NO
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Strabismus: <input type="checkbox"/> YES <input type="checkbox"/> NO	Hypertension: <input type="checkbox"/> YES <input type="checkbox"/> NO	Other:
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All Professional services rendered are charged to the patient if partial/full payment is not received by insurance. It is the patient's responsibility to contact their insurance company prior to services being rendered to ensure we are an in-network provider. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. My signature authorizes release of the information to the insurer or agency shown. In Medicare/Other Insurance company assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare/Other Insurance company as the full charge and the patient is responsible only for the deductible, co-insurance and non-covered services. Deductible and co-insurance are based upon the charge determination of Medicare/Other Insurance company.

Patient/Guardian Signature: _____ **Date:** _____