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? ☐ YES ☐ NO	Glaucoma: ☐ YES ☐ NO	Eye Injury/Surgery: ☐ YES ☐ NO
Amblyopia (“lazy eye”) ☐ YES ☐ NO	Cataract: ☐ YES ☐ NO	Macular Degeneration: ☐ YES ☐ NO
Strabismus (eye wander/cross): ☐ YES ☐ NO	Dry Eye: ☐ YES ☐ NO	Other:

High Blood Pressure: ☐ YES ☐ NO	Stroke: ☐ YES ☐ NO	Tobacco User: ☐ PAST ☐ CURRENT ☐ NEVER
High Cholesterol: ☐ YES ☐ NO	Anxiety/Depression: ☐ YES ☐ NO	Cancer: ☐ YES (Type: ________________) ☐ NO
Heart Disease: ☐ YES ☐ NO	Thyroid Disease: ☐ YES ☐ NO	Arthritis: ☐ YES (Type: ________________) ☐ NO
Diabetes: ☐ YES ☐ NO	Allergies: ☐ YES ☐ NO	Other:

FLU SHOT? ☐ YES ☐ NO IF YES, YEAR? ________ PNEUMONIA VACCINE? ☐ YES ☐ NO IF YES, YEAR? ________

FAMILY OCULAR/MEDICAL HEALTH HISTORY (leave blank if Unknown)

Diabetes ☐ YES ☐ NO	Glaucoma: ☐ YES ☐ NO	Mac Degeneration: ☐ YES ☐ NO	Heart Disease: ☐ YES ☐ NO
Amblyopia ☐ YES ☐ NO	Cancer: ☐ YES ☐ NO	High Cholesterol: ☐ YES ☐ NO	Thyroid Disease: ☐ YES ☐ NO
Strabismus: ☐ YES ☐ NO	Hypertension: ☐ YES ☐ NO	Other:	

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:** __________________________