PATIENT INFORMATION FORM

PLEASE PRINT CLEARLY

Last Name: _____ First Name: _____ M.I.____
Title: Dr./ Mr./ Mrs./ Ms./ Rev. Nickname: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home phone: (_____)_____ Work phone: (_____)_____
Cell phone: (_____)_____ Email: _____

How do you prefer our office contact you (check all that apply)
Phone ___
E-mail ___
Text ___

Primary influence for selecting our practice:

_____ Referred by: _____
_____ Insurance Panel List
_____ Internet/ Website
_____ Walk-In
_____ Other: _____

Gender: Male/ Female Date of Birth: _____ Age: _____
Social Security Number: _____
Marital status: Married/ Divorced/ Single/ Widow(er)/ Domestic Partner

Employer or School: _____
Occupation: _____
Preferred Language: _____ Race: _____

Guarantor information (who will be responsible for this account?)
_____ Check here if same as above

If the guarantor information is different please fill in information below

Name: _____ Relationship to Patient:_____
Address: _____
City: _____ State: _____ Zip Code: _____
Home phone: (_____) _____ Cell Phone: (_____) _____

All patients please read and sign below

I authorize Drs Eyecare to release any medical information to my insurance company (or companies) and to accept assignment of benefits. I understand that I may have co-payments and overages (costs not paid for by the eye care and/or medical plan), and I am ultimately responsible for all fees incurred.

Patient or Responsible Party's Signature _____ Date:_____

Notice of Privacy Practices Acknowledgment

I acknowledge that I received a copy of Drs Eyecare's Notice of Privacy Practices.

Patient Name: _____ Date: _____

Signature:_____

MEDICAL HISTORY

PLEASE PRINT CLEARLY Today's Date: _____

Last Name _____ First Name _____ M.I. _____

Purpose of your visit _____

_____ Date of last eye exam _____

Date of last physical exam _____ Primary Care Physician _____

Phone number for Primary Care Physician _____

Are you allergic to any of the following? Penicillin _____ Sulfa _____

Codeine _____ Latex _____ Other _____

Please list all medications you are currently taking (including oral contraceptives, aspirin, over-the-counter medications, vitamins and supplements) _____

_____

_____

_____

List any eye surgeries _____

Circle/List any of the following that you have had – crossed eyes, lazy eye, drooping eyelid, glaucoma, retinal disease, cataracts, eye infections, or eye injuries. _____

_____

Are you pregnant and/or nursing? yes _____ no _____

Do you wear glasses? yes _____ no ____ If yes, how old are your current glasses? _____

Do you wear contact lenses? yes ____ no ____ Are your contacts comfortable? _____
If yes, how old are your current contacts? _____
If yes, what's the brand of contacts you wear? _____
If yes, are your contacts – Rigid ____ Soft _____ Extended Wear _____

FAMILY MEDICAL HISTORY
Please list the family member(s) with the following eye or medical conditions:

Disease/ Conditions		Family member (ie mother, father, brother, sister)
1. Cancer	yes/no	_____
2. Diabetes	yes/no	_____
3. Hypertension	yes/no	_____
4.Thyroid	yes/no	_____
5. Cataract	yes/no	_____
6. Macular Degeneration	yes/no	_____
7. Glaucoma	yes/no	_____
8. Other	yes/no	_____

SOCIAL HISTORY
Do you currently drive? yes _____ no _____ Do you have visual difficulties when driving?
yes ___ no___ If yes, please describe _____
Do you use tobacco products? yes ____ no ____
If yes, please list the brand, amount per day, and how long have you been smoking?
_____

REVIEW OF SYSTEMS: Do you have any health problems related to the following?
Please circle. If yes, please explain.

SYSTEM	**YES/NO**	**EXPLAIN/MEDICATIONS**
Constitution		
Cancer	yes/no	_____
Other	yes/no	_____
Ear,Nose and Throat		
Hearing Loss	yes/no	_____
Sinusitis	yes/no	_____
Dry Mouth	yes/no	_____
Other	yes/no	_____
Neurological		
Multiple Sclerosis	yes/no	_____
Epilepsy	yes/no	_____
Stroke/CVS	yes/no	_____
Migraine	yes/no	_____
Other	yes/no	_____
Psychiatric		
Depression	yes/no	_____
Attention Deficit	yes/no	_____

Anxiety Disorder	yes/no	_____
Other	yes/no	_____
Cardiovascular		
Hypertension	yes/no	_____
Heart Disease	yes/no	_____
Vascular Disease	yes/no	_____
Other	yes/no	_____
Respiratory		
Asthma	yes/no	_____
Bronchitis	yes/no	_____
Emphysema	yes/no	_____
COPD	yes/no	_____
Sleep Apnea	yes/no	_____
Other	yes/no	_____
Gastrointestinal		
Crohns	yes/no	_____
Colitis	yes/no	_____
Ulcer	yes/no	_____
Acid Reflux	yes/no	_____
Other	yes/no	_____
Genitourinary		
Kidney Disease	yes/no	_____
Other	yes/no	_____
Muscular/Skeletal		
Arthritis	yes/no	_____
Osteoarthritis	yes/no	_____
Fibromyalgia	yes/no	_____
Gout	yes/no	_____
Other	yes/no	_____

Integumentary/Skin		
Eczema	yes/no	_____
Rosacea	yes/no	_____
Psoriasis	yes/no	_____
Other	yes/no	_____
Endocrine		
Type 2 Diabetes	yes/no	_____
Type 1 Diabetes	yes/no	_____
Thyroid Dysfunction	yes/no	_____
Hormonal Dysfunction	yes/no	_____
Other	yes/no	_____
Hemotologic/Lymphatic		
Anemia	yes/no	_____
Hypercholesterolemia	yes/no	_____
Other	yes/no	_____
Allergic/Autoimmune		
Environmental Allergies	yes/no	_____
Rheumatoid Arthritis	yes/no	_____
Lupus	yes/no	_____
Sjogrens Syndrome	yes/no	_____
Other	yes/no	_____ _____