

PATIENT HISTORY

(Please Print)

Name: (Mr. Mrs. Miss) _____
(Dr. Ms. Rev.) (First) Middle (Last) (Nickname?)

Address: _____ Second Address? _____

City _____ State: _____ Zip: _____

Date of Birth: _____ / _____ / _____ Home Phone#: _____

Employer's Name & Phone #: _____

Spouse's Name: _____

If minor, parent or guardian's first and last name: _____

Circle those eye conditions for which **you** have been or are presently being treated:

- | | | | |
|-------------------------------|--------------------------------------|--------------------|---------------------------|
| Muscle surgery (crossed eyes) | Injury in or around eye | Dry eye | Glaucoma |
| Eye infection | Cataract surgery | Refractive surgery | Lazy eye/Amblyopia |
| Lid surgery (droopy eyelids) | Laser for Post Cataract Surgery Haze | Diabetic laser | Retinal Detachment (tear) |
| Lid Surgery (Other) | Stye/Chalazion | Eye Allergies | |

What vision or eye problems are you experiencing now? _____

How did you select our office for your eye care? Phone Book? _____ Insurance Book _____

Personal referral; if so, whom may we thank? _____

Would you like us to mail you a reminder when it is time for your next eye exam? Yes No

LIFETIME MEDICARE B AND/OR INDEPENDENT INSURANCE SIGNATURE AUTHORIZATION

I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare or Independent insurance claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services OR authorize such physician or organization to submit a claim to Medicare or independent insurance company for payment to me.

_____ Patient's Signature	_____ Medicare Number	_____ Date
_____ Social Security #	_____ Medicaid 10 digit #	_____
_____ Other Insurance Co. or Medicaid Gold Card #	_____ Policy Number	_____ Address

Name: _____ Today's Date: ____ / ____ / ____
First Last

Last Medical Exam: ____ / ____ / ____ Last Eye Exam: ____ / ____ / ____

Name of Family Medical Doctor: _____ Dr.'s Phone: _____

Address: _____

Medical History

Do you have any allergies to medications? no yes If yes, list: _____

List any medications you take now (including oral contraceptives, aspirin, over the counter medications and home remedies): _____

List all major serious injuries, surgeries, diseases and/or hospitalizations **you** have had (except for eyes): _____

Are you pregnant and/or nursing? no yes non applicable

Do you wear glasses? no yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? no yes If yes, how old is your present pair of lenses? _____

Are they comfortable no yes

Type of contact lenses (Check all that apply): Rigid Soft Extended Wear oxygen permeable disposable
 toric (astigmatism) monofit bifocal

Family History

This section is **not you or your spouse**, but concerning your mother, father, brothers, sisters, aunts, uncles, grandmother, grandfather .

DISEASE/CONDITION **RELATIONSHIP TO YOU** (circle the one that apply)

	Mother	Father	Brother	Sister	Grandmother	Grandfather	Aunt	Uncle
Blindness								
Cataract								
Crossed Eyes/Lazy Eye								
Glaucoma								
Macular Degeneration								
Retinal Detachment/Disease								
Arthritis								
Cancer								
Diabetes								
Heart Disease								
High Blood pressure								
Kidney Disease								
Lupus								
Thyroid Disease								
Other Eye Disease								

Social History (Optional) (This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.)

Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

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

Do you use tobacco products? no yes

Do you drink alcohol? no yes

