

PATIENT HEALTH HISTORY

(Please Print)

Last Name: _____ First: _____ Middle: _____ Sex: Male Female

Date of Birth: ____/____/____ Age: _____ Referred By: _____

Primary Physician: _____ Phone: (____) _____

1. Are you currently experiencing any eye symptoms? Yes No (If Yes, please check all that apply.)

- | | | | | | |
|--------------------------------|-------------------------------------|-----------------------------------|--|--|---|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Redness | <input type="checkbox"/> Tearing | <input type="checkbox"/> Dryness | <input type="checkbox"/> Burning Sensation | <input type="checkbox"/> Foreign Body Sensation |
| <input type="checkbox"/> Glare | <input type="checkbox"/> Irritation | <input type="checkbox"/> Itching | <input type="checkbox"/> Discharge | <input type="checkbox"/> Light Sensitivity | <input type="checkbox"/> Decreased Vision |
| <input type="checkbox"/> Halos | <input type="checkbox"/> Floaters | <input type="checkbox"/> Swelling | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Flashes of Light | <input type="checkbox"/> Blurred Vision |

Other: _____

2. Have you been previously diagnosed with any of the following eye diseases? (Please check all that apply.)

- | | | | | |
|---|---|---|--|---|
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Blepharitis | <input type="checkbox"/> Lid or Skin Lesions | <input type="checkbox"/> Vitreous Detachment | <input type="checkbox"/> Amblyopia "Lazy" Eye |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Uveitis | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Corneal Erosion | <input type="checkbox"/> Dry Eye Syndrome |
| <input type="checkbox"/> Optic Nerve Disorder | <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Choroidal Nevus | <input type="checkbox"/> Retinal Disease | |

Other: _____

3. Have you ever had any eye surgery? Yes No If Yes, please provide date(s) and reason(s) below:

4. Do you take any eye medications? Yes No If Yes, please list below:

5. Have you ever been hospitalized? Yes No If Yes, please provide date(s) and reason(s) below:

6. Do you take any other medications? Yes No If Yes, please list below: (attach list if necessary)

7. Do you have any drug or food allergies? Yes No If Yes, please list below:

Have you ever been treated for any medical conditions? (e.g. diabetes; high blood pressure; arthritis, etc.)

Yes No If Yes, please list:

Review of Systems ~ Do you currently have any of the following conditions? Please circle Yes or No. If Yes, please explain.

- | | | | |
|--|-----|----|-------|
| Chronic fever, unexpected weight loss/gain; fatigue; sleep loss; etc. | Yes | No | _____ |
| Ear/nose/throat problems (e.g. hearing loss; sinus; sore throat,) | Yes | No | _____ |
| Cardiovascular (e.g. chest pain; irregular heart beat; circulation) | Yes | No | _____ |
| Respiratory problems (e.g. shortness of breath; wheezing; coughing) | Yes | No | _____ |
| Gastrointestinal issues (e.g. heartburn; abdominal pain; diarrhea; vomiting) | Yes | No | _____ |
| Urinary problems (e.g. pain or discomfort; blood in urine) | Yes | No | _____ |
| Skin Problems (e.g. rashes; excessive dryness; bruising) | Yes | No | _____ |
| Musculoskeletal problems (e.g. muscle aches; joint pain; swollen joints) | Yes | No | _____ |
| Neurological problems (e.g. numbness; weakness; headaches; paralysis) | Yes | No | _____ |
| Hematological, Lymphatic (e.g. blood disorders; leukemia) | Yes | No | _____ |
| Allergic, Immunologic (e.g. allergies; hay fever) | Yes | No | _____ |
| Endocrine problems (e.g. thyroid issues) | Yes | No | _____ |
| Psychiatric problems (e.g. depression; anxiety) | Yes | No | _____ |

Family and Social History ~

Occupation: _____ If employed how many hours per week do you work? _____

Do any medical or eye diseases run in your family? (e.g. diabetes; high blood pressure; cancer; glaucoma; macular degeneration)

Yes No If Yes, please explain: _____

Do you smoke? If yes, how much? _____ Drink Alcohol? If yes, how much? _____

Doctor's Signature

Date

PATENT INFORMATION

(Top Portion for Office Use Only)

New Patient Name Change Address Change Insurance Change

To insure proper billing, please print when you complete all forms.
We will need to copy your insurance card(s). Please have available.

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: ___/___/___ Age: ___ Social Security # _____ Sex: Male Female

Address: _____
Street City State Zip

Home Phone: () _____ Work Phone: () _____

Cell Phone: () _____ e-mail: _____

Please check which phone number you would like us to use for reminder calls and as your main contact.

Is it acceptable for our office to leave messages at this number? YES NO

PARENT, SPOUSE OR RESPONSIBLE PARTY (if different from Patient)

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: ___/___/___ Relationship to Patient: _____ Phone: () _____

Other family members that are patients: _____

How were you referred to this office? _____

Emergency Contact: _____ Phone: () _____

Please list all those authorized to receive patient medical information? (Including physicians.)

Name(s): _____

INSURANCE COVERAGE INFORMATION ~ PRIMARY: (You may skip this section if you present card(s) to our staff.)

Medical Insurance Plan: _____ ID#: _____

Separate Vision Plan: _____ ID#: _____

Name of Policy Holder: _____ Date of Birth: ___/___/___

Relationship to Patient: _____ Employer Name: _____

If patient is under 18 or a student, check relationship: Mother Father Other: _____

Do you have Medicare/Medicaid Yes No

Do you have any other Secondary Insurance? Yes No

Name of Insurance: _____ Policy ID#: _____

Relationship to Patient: _____ Date of Birth: ___/___/___

AUTHORIZATION AND ASSIGNMENT OF BENEFITS:

I understand that I am responsible for payment of co-payments, annual deductibles, and any coinsurance or non-covered benefit at the time of service. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information about me to release to Centers for Medicare and Medicaid Services, its agents, or any insurance carrier I may have; any information needed to determine these benefits or the benefits payable for related services. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to receive payment. Any outstanding balances billed after my insurance processes is due upon receipt of billing statement.

Patient or responsible Party Signature: _____

Date: ___/___/___ Print Name: _____

PATIENT INFORMATION