PATIENT INFORMATION SHEET

MR / MRS / MS / DR ____
(FIRST) (MI) (LAST)

MAILING ADDRESS:____
(STREET)

CITY: ______________________ STATE: ____ ZIP: __________

PHONE: (HOME)______________(CELL)______________(WORK)____________

PREFERED PHONE: ☐ HOME ☐ CELL ☐ WORK

E-MAIL ADDRESS:________________________@________________________
(please note that we do not give out our email addresses,
nor use them for anything other than appointment related contact)

PREFERRED WAY TO RECEIVE APPOINTMENT REMINDERS: ☐ PHONE ☐ EMAIL ☐ TEXT MESSAGE

PREFERRED WAY TO RECEIVE RECALL REMINDERS: ☐ PHONE ☐ EMAIL

DATE OF BIRTH: ____ / ____ / ________ AGE: ________

SOCIAL SECURITY #: _____ - _____- ______

MARITAL STATUS: ☐SINGLE ☐ MARRIED/PARTNERED ☐WIDOWED ☐DIVORCED

SPOUSE/PARTNER/NEXT OF KIN: ______________________ PHONE: __________________

PERSON RESPONSIBLE FOR BILL: ______________________________________

WHO IS YOUR PRIMARY CARE DOCTOR? ______________________________________

REFERRED BY (DOCTOR): ________________________

REFERRED BY (OTHER): ________________________

HOW DID YOU HEAR ABOUT US: ______________________________________

EMPLOYER:__________________ OCCUPATION:________________________

THE FOLLOWING QUESTIONS ARE ASKED FOR PATIENT PROTECTION AND THE AFFORDABLE CARE ACT (ACA):

PREFERRED LANGUAGE: ☐ ENGLISH ☐ OTHER (Specify)______________________________

RACE: ☐ AMER INDIAN ☐ ALASKA NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN

☐ NATIVE HAWAIIAN ☐ OTHER PACIFIC ISLANDER ☐ WHITE

☐ DECLINE TO ANSWER ☐ UNKNOWN

ETHNICITY: ☐ HISPANIC or LATINO ☐ NOT HISPANIC or LATINO ☐ DECLINE TO ANSWER ☐ UNKNOWN

INSURANCE

INSURANCE INFORMATION: WE WILL SUBMIT YOUR CLAIM FOR YOU. PLEASE PRESENT YOUR CARD TO THE RECEPTIONIST.

______ I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS
(initial) CLAIMS FOR MEDICAL BENEFITS.

I UNDERSTAND AND AGREE THAT REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

I WILL BE PAYING TODAY BY: CASH ____ CHECK ____ CREDIT CARD _____ FSA _______

____ _______________

(SIGNATURE OF PATIENT) (DATE)

NOTE: IF YOU ARE **NOT** THE PRIMARY SUBSCRIBER OF INSURANCE YOU ARE USING, PLEASE PROVIDE THE FOLLOWING:

PRIMARY SUBCRIBER NAME: ______________________________ DATE OF BIRTH: _______________

LAST 4 DIGITS of SOCIAL SECURITY #, if known : ___ ___ ___ ___

MEDICAL HISTORY QUESTIONNAIRE

NAME:____ **DATE:**________________________

WHAT IS YOUR REASON FOR REQUESTING AN EXAM____

____

ARE YOU HAVING ANY EYE PROBLEMS?____

PAST EYE HISTORY

HAVE YOU EVER HAD ANY EYE DISEASES, INJURIES OR SURGERY? YES / NO

IF "YES" EXPLAIN____

____

DO YOU WEAR EYEGLASSES NOW? YES / NO

DO YOU WEAR CONTACT LENSES NOW? YES / NO

ARE YOU INTERESTED IN ANY SPORTS EYEWEAR? YES / NO

ARE YOU INTERESTED IN CONTACT LENSES? YES / NO

ARE YOU INTERESTED IN SUNGLASSES? YES / NO

MEDICAL HISTORY REVIEW

DO YOU PRESENTLY HAVE ANY PROBLEMS IN THE FOLLOWING AREAS: (IF "YES", EXPLAIN)

HEAD & NECK	YES / NO	____________________
EAR, NOSE, THROAT	YES / NO	____________________
HEART	YES / NO	____________________
LUNGS	YES / NO	____________________
BONES, JOINTS & MUSCLES	YES / NO	____________________
SKIN	YES / NO	____________________
NERVOUS SYSTEM	YES / NO	____________________

<u>DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?</u>

DIABETES	YES / NO	GLAUCOMA	YES / NO
CHRONIC INFECTIONS	YES / NO	BLEEDING DISORDER	YES / NO
CANCER	YES / NO	HIGH BLOOD PRESSURE	YES / NO
INFLAMATORY DISEASE	YES / NO	ASTHMA OR ALLERGIES	YES / NO
HIGH CHOLESTEROL	YES / NO	SEIZURES, CONVULSIONS	YES / NO

DO YOU USE CIGARETTES/TOBACCO?_______________ALCOHOL?_____________OTHER SUBSTANCE? ____________

OTHER RELEVENT HISTORY (PLEASE LIST)____

LIST ANY MEDICATIONS YOU TAKE: ____

ALLERGIES: Yes No Seasonal? ___________________other? __________________________________

LIST ANY MAJOR ILLNESSES YOU HAVE HAD IN THE PAST: ____

FAMILY HISTORY

IS THERE A **FAMILY HISTORY** OF ANY OF THE FOLLOWING CONDITIONS? **IF YES**, PLEASE INDICATE **FAMILY MEMBER**. (Mother, Father, Sibling, Grandparent)

GLAUCOMA	YES / NO	____________	RETINITIS PIGMENTOSA	YES / NO	____________
CATARACT	YES / NO	____________	MACULAR DEGENERATION	YES / NO	____________
BLINDNESS	YES / NO	____________	RETINAL DETACHMENT	YES / NO	____________
DIABETES	YES / NO	____________	OTHER____________________		