**Patient Information Form**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Information**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_ Gender: M/F

Last First Middle  Please Circle One

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name/Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who referred you to our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last eye exam? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Doctor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race(Optional) 􀂉 Black –Non Hispanic 􀂉 American Indian/Alaskan Native 􀂉 Hispanic 􀂉 Asian/Pacific Islander

􀂉 White –Non Hispanic􀂉 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information**

Major Medical: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Medical: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vision Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber’s SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Relationship to Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature on File**

1. I authorize the use of this form on all my insurance submissions.
2. I authorize release of information to all my insurance companies.
3. I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
4. I authorize payment direct to my doctor.
5. I permit a copy of this authorization to be used in place of the original.
6. I request that payment of authorized Medicare and/or insurance be made either to me or on my behalf to my doctor for any services furnished.

I authorize any holder of medical information about me to release to the health care financing administration and its agents information needed to determine these benefits payable for related services.

7. I understand I am responsible for any amount of my bill not covered by my insurance.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT MEDICAL INFORMATION

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Visit:

\_\_\_\_\_\_\_ Possible medical eye problem

\_\_\_\_\_\_\_ Routine eye examination

\_\_\_\_\_\_\_ Interested in contact lenses or refractive surgery

Eye Conditions and Symptoms:

\_\_\_\_ Glaucoma \_\_\_\_ Glasses Use \_\_\_\_ Redness

\_\_\_\_ Cataract \_\_\_\_ Contact Problem \_\_\_\_ Tearing/Discharge

\_\_\_\_ Retinal Problems \_\_\_\_ Blurred Vision \_\_\_\_ Double Vision

\_\_\_\_ Headache \_\_\_\_ Eye Pain \_\_\_\_ Floaters/Flashing

\_\_\_\_ Eye Injuries \_\_\_\_ Eye Infection \_\_\_\_ Eyelid Problems

\_\_\_\_ Dry Eye \_\_\_\_ Eye Itching \_\_\_\_ Halos

Past or Current Medical Problems: (check if YOU have had any of these problems):

\_\_\_\_ Diabetes \_\_\_\_ High Blood Pressure \_\_\_\_ High Cholesterol

\_\_\_\_ Weight Change \_\_\_\_ Fever \_\_\_ Migranes

\_\_\_\_ Sinus Infections \_\_\_\_ Ear Nose Throat \_\_\_\_ Thyroid Trouble

\_\_\_\_ Heart Disease \_\_\_\_ Allergy/Hay Fever \_\_\_\_ Bronchitis

\_\_\_\_ Shortness of Breath \_\_\_\_ Asthma \_\_\_\_ Urinary Problem

\_\_\_\_ Arthritis/Joint Pain \_\_\_\_ Gastrointestinal Prob .\_\_\_\_ Kidney Stones

\_\_\_\_ Dizziness \_\_\_\_ Rash/Skin Disorder \_\_\_\_ Neurological

\_\_\_\_ Memory Loss \_\_\_\_ Seizure \_\_\_\_ Cancer

\_\_\_\_ Depression \_\_\_\_ Stroke/Paralysis \_\_\_\_ Immune Problem

\_\_\_\_ Circulation Problem \_\_\_\_ Anemia \_\_\_\_ HIV Positive

\_\_\_\_ On a Blood Thinner \_\_\_\_ Bleeding Tendency \_\_\_\_ Gout

Do you Drive? Y/N Do you smoke? Y/N or Former Smoker

Do you Drink Alcohol? None/Socially/Daily

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family History:

\_\_\_\_ Glaucoma \_\_\_\_ Cataracts \_\_\_\_ Blindness

\_\_\_\_ Diabetes \_\_\_\_ Macular Degeneration \_\_\_\_ Muscle Imbalance

\_\_\_\_ Glasses Use \_\_\_\_ Retinal Problem

Do you have any allergies to medications: Yes/No. If so please list them:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list All Medications you are taking: ( ) None

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_