PATIENT INFORMATION FORM

Name:_____DOB_____

Preferred name or nickname:_____

Address:_____

_____

Home phone_____Cell_____Work_____

Email:_____

How would you like to be contacted? Home phone_____Text_____Email_____

Name of medical doctor_____Doctors phone_____

Name of pharmacy_____location_____

Name of employer_____

Name of Medical Insurance_____

Primary (policy holder) on the insurance_____DOB_____

Do you need referrals for your medical insurance? Yes / No (circle one)

Name of Vision insurance_____

What brings you in for your visit today?_____

Whom may we thank for referring you to our office?_____

Please read and sign below

I am responsible for payment of services provided to me. If I have insurance I agree by signing below that I am responsible for any charge not covered or denied by my insurance company. **If my insurance requires a referral it is my responsibility to obtain one.** I release any necessary medical information related to my care that is necessary to properly process an insurance claim.

It is the patient's responsibility to present insurance at the time of the exam. No refunds or adjustments can be made after the exam date.

Signature_____Date_____
(Parent signature for a minor)

NAME:_____ DATE OF BIRTH _____/_____/_____

Medical History (circle all that apply for each section or circle none of the above)

Constitutions:
fatigue syndrome
cancer (type_____)
developmental disabilities
none of the above

Ear/Nose/Throat:
hearing loss
dry mouth/laryngitis
sinusitis
none of the above

Neurological:
stroke/cerebrovascular accident
tumor
migraines
multiple sclerosis
cerebral palsy
epilepsy
None of the Above

Psychology
anxiety disorder
bipolar disorder
depression
attention deficit
None of the Above

Cardiovascular:
High Blood Pressure (hypertension
Stroke/CVA (cerebral vascular accident)
heart disease
vascular disease
congestive heart failure
None of the Above

Respiratory:
Bronchitis
Emphysema
Asthma
Chronic Obstruction (COPD)
Sleep Apnea
None of the Above

GI:
Acid Reflux
Ulcer
Colitis
Crohn's
Celiac disease
None of the Above

GU:
Prostate disease/cancer
Kidney Disease
STD (sexually transmitted disease)
None of the Above

Muscle/Skeletal:
Ankylosing Spondylitis
Muscular dystrophy
Fibromyalgia
Osteoarthritis
Arthritis
None of the Above

Skin:
Rosacea
Psoriasis
Herpes simplex/cold sores
Herpes Zoster/Shingles
Eczema
None of the Above

NAME_____

Endocrinology:	**Blood/Lymphatic :**	**Allergy:**
Type 2 Diabetes	Anemia	Environmental Allergies
Type 1 Diabetes	Elevated cholesterol	Sjogrens Syndrome
Thyroid dysfunction	**None of the Above**	Lupus
None of the Above		**None of the Above**

Do you use tobacco products: YES/NO
Did you ever; YES/NO
If yes: everyday/occasional use Please circle: Cigarettes cigars other

Are you currently pregnant or nursing YES/NO

Allergies to Medication/ environment /food:_____
_____

MEDICATIONS/ HERBS/ VITAMINS:
(if you have a list we can copy do not fill this in)

Name	Dosage	Name	Dosage
_____		_____	
_____		_____	
_____		_____	
_____		_____	

Your eyes: (circle all that apply)

trauma	surgery	dry eye
retinal detachment	glaucoma	macular degeneration
cataract	allergy	patching/lazy eye
inflammatory disorder		floaters
loss of vision		flashes of light

Do you: wear glasses? YES/NO all the time / distance/ near
Do you: wear contacts? YES/NO Do you want contacts? YES/NO

FAMILY HISTORY:(please indicate mom, dad, sister, brother, grandparent, children)

Cancer	Macular degeneration
Thyroid disease	Retinal Detachment
High Blood Pressure	Glaucoma
Diabetes	Cataracts
Lazy eye	

Please list any additional information you feel is important for your exam today.
_____
_____