

## Patient Information Sheet

# WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form. If you have questions or need assistance we will be glad to help you.

### PATIENT INFORMATION

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient's SS# \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

### INSURANCE

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Company \_\_\_\_\_

Group # \_\_\_\_\_

Is Patient covered by additional insurance? \_\_\_\_ Yes \_\_\_\_ No

Subscriber Name \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Company \_\_\_\_\_

Group # \_\_\_\_\_

**Our practice continues to grow through the kind referrals of our patients. From whom, or how did you find out about our practice?** \_\_\_\_\_

### Family Information: (For parents with children living at home)

Parents

Children living at home

Birth Year

Father \_\_\_\_\_

Mother \_\_\_\_\_

How do you wish to pay for today's visit? Cash \_\_\_\_\_ Check \_\_\_\_\_ Charge Card \_\_\_\_\_ Insurance \_\_\_\_\_

**Medical History**

Physician's Name \_\_\_\_\_

Date of last visit \_\_\_\_\_

Date of your last eye examination \_\_\_\_\_

Eye Doctor's Name \_\_\_\_\_

What is the **primary** reason for today's visit? \_\_\_\_\_

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Place a checkmark in the box to indicate any condition that applies to you or a family member.

	You	Family Member		You	Family Member
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>
Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Turned Eye	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use tobacco	<input type="checkbox"/>	<input type="checkbox"/>

Please list any medications that you use including eye drops:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

What medications are you allergic to? \_\_\_\_\_