

## PATIENT INFORMATION SHEET

NAME:		DATE:	SEX:
ADDRESS:		AGE:	BIRTHDATE:
CITY:	STATE:	ZIP:	SOCIAL SECURITY:
HOME PHONE:	DRIVER'S LICENSE NUMBER:		OCCUPATION:
EMPLOYER'S NAME:	ADDRESS:	PHONE:	
MARITAL STATUS:	SPOUSE'S NAME:	SPOUSE'S WORK PHONE:	

WHO REFERRED YOU? \_\_\_\_\_

PRIMARY INSURANCE:	MEMBER #:
SUBSCRIBER NAME:	SUBSCRIBER SOCIAL SECURITY #:
SECONDARY INSURANCE:	MEMBER #:
SUBSCRIBER NAME:	SUBSCRIBER SOCIAL SECURITY #:

WHO MAY WE CONTACT IN CASE OF AN EMERGENCY? \_\_\_\_\_

RELATIONSHIP? \_\_\_\_\_

PHONE #: \_\_\_\_\_

<u>DO YOU HAVE A HISTORY OF:</u>	<u>DO YOU OR ANY OF YOUR FAMILY HAVE:</u>	<u>RELATIONSHIP:</u>
YES NO HYPERTENSION	YES NO GLAUCOMA	_____
YES NO DIABETES (DURATION)	YES NO BLINDNESS	_____
YES NO STROKE / TIA	YES NO MACULAR DEGENERATION	_____
YES NO LUNG DISEASE / ASTHMA	YES NO CATARACTS	_____
YES NO HEART DISEASE (TYPE):	YES NO COLOR BLINDNESS	_____
_____	YES NO POOR NIGHT VISION	_____

PLEASE LIST PREVIOUS OCULAR OPERATIONS / INJURY / DISEASE: \_\_\_\_\_

DO YOU HAVE ANY DRUG ALLERGIES? \_\_\_\_\_

WHAT IS YOUR REACTION TO THESE MEDICATIONS? \_\_\_\_\_

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: \_\_\_\_\_

PLEASE LIST ALL MAJOR OPERATIONS: \_\_\_\_\_

DO YOU OR HAVE YOU EVER HAD ANY SYSTEMIC ILLNESS? Please Explain: \_\_\_\_\_

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account, and for any professional or diagnostic services rendered as well as any glasses or contacts ordered. I authorize payment of medical benefits payable to the physician. A copy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or changes in any of the information provided on the patient information sheet. I also authorize this office to release my spectacle or contact lens prescription at my request.

Patient Initials: \_\_\_\_\_

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

\_\_\_\_\_  
PATIENT SIGNATURE:

\_\_\_\_\_  
PATIENT NAME: (please print)