PATIENT HISTORY FORM **TODAY'S DATE** ________________

Name:________________________________ D.O.B:____________ SocSecurity# ________________
Address:____ City:____________ State:______ Zip:________
Tel:Home____________________ Work:______________________ Cell:______________________
How did you hear about us? ____________________________
Insurance: __________________________ Employer/Occupation: ______________________________
Emergency contact person: Name __________________ Relationship: ______________ Tel: ______________

We are now making greater use of e-mail to communicate with our patients. To help us provide the most prompt service possible. Please enter your current e-mail address below:

NOTE: ALL PATIENT INFORMATION IS KEPT STRICTLY CONFIDENTIAL. YOUR ADDRESS IS **NEVER** SHARED!

MEDICAL HISTORY

Date of last eye exam: ____________________ By whom ______________________________
When was the last time you had a dilated eye exam: ______________________________________
Reason for today's exam: ____
Contact lens type: ______________ Age of lens____________ Disinfection type: ______________
Who's your family doctor? ______________________ Phone: ____________________________

Please answer yes or no to the following questions:

Do you work on a computer? YES______ NO______ Do you have difficulty driving at night? YES______ NO______
Do you have trouble with glare? YES_____ NO_____ Do you work under fluorescent lighting? YES_____ NO______
Would you like to try contacts? YES_____ NO______

In order to have a better evaluation of the inside of your eyes & peripheral retina, we may need to put drops and dilate your eyes. This can make your near vision blurry, light sensitive & difficulty driving for up to 4 hours.
I do__ do not__ give my permission to have my eyes dilated today: ______________________________
Patient / Legal Guardian Signature

Financial Responsibility Statement & HIPPA Practice Acknowledgement:
All payments are due at the time of service rendered. Your insurance is not a substitute for payment, as all benefits quoted are not a guarantee of payment. It is your responsibility to pay for any co-pays, deductibles, or any other balance not covered under your insurance. In signing this statement you agree to be financially responsible for all charges.
I authorize any holder of medical information about me, to release to the Health Care Financing administrative and its agents any information needed to determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. Photocopy of this assignment is considered to be as valid as the original.

Patient / Legal Guardian Signature ______________________________ Date ______________

Medical Referral: I agree for the release of my exam record to other healthcare providers if a referral is necessary.

Patient / Legal Guardian Signature ______________________________ Date______________

(FOR DOCTOR USE ONLY) DIALATED YES / NO
CC:____
____
____

Notes:

Habitual RX:________________________
____

Ocular Health___ DFE:____________________ Plan:______________________________
________________________ ______________________________

FINAL RX:________________________ Doctors name:______________________________
________________________ Signature:______________________ Date:__________

Ocular History: (Please mark all of the following that apply):

Retinal Detachment ____ Blindness ____ Eyestrain w/ Headaches ____ Eye Surgery____
Eye Injury ____ Glaucoma ____ Macular Degeneration____ Other__________

Medical History: (Please mark any of the following that apply to you):

Medication:
Are you taking any medications? ___No __Yes (if yes, please list ALL): ______________________________

Allergic/Immunologic:
Environmental Allergy ____ Rheumatoid Arthritis ____ Lupus____
Drug Allergy ____ Other(Please list ALL)______________________________

Smoking Status:
Never Smoked ___ Current Smoker ___(Everyday/Someday) Former Smoker _____

What is your Height:______________ Your Weight:______________

Musculoskeletal:
Fibromyalgia____ Ankylosing Spondylitis____ Muscular Dystrophy____ Osteoarthritis____

Cardiovascular:
Heart Disease _____ Hypertension ____ Stroke _____ Vascular Disease ____ Other_________

Neurological:
Multiple Sclerosis_____ Epilepsy____ Alzheimer____ Cerebrovascular_____ Parkinson_____

Constitutional:
Weight Loss____ Developmental Disability____ Fever____ Fatigue____ Trauma____

Genitourinary:
STD/Viral Herpetic/ Chlamydia: ___________ Other_______

Psychiatric:
Depression _____ Panic Disorder: ____ Schizophrenia: ____ Other: ______________

Hematologic/Lymphatic:
Anemia____ Large Volume Blood Loss____ Leukemia____ Other___________

Respiratory:
Asthma_____ Bronchitis____ Emphysema____ Other: ______________________________

Endocrine:
Insulin Dependent diabetic_____ Non-Insulin dependent diabetic____ Thyroid Dysfunction _____
Hormonal Dysfunction______

Integumentary:
Eczema _____ Rosacea_____ Psoriasis _____ Other ______________________________

Family History:

Diabetes_________ Hypertension ________ Glaucoma________ Macular degeneration_______
Color blindness________ Cataract________ Blindness________

Patient Signature:______________________________ Date:______________