PORTLAND EYE CARE

Patient Intake Form

LAST NAME: ______________________________ FIRST NAME: ____________________________ MIDDLE INITIAL: ______

M / F DATE OF BIRTH: _______/_______/________ SSN: ______-______-_______ MARITAL STATUS: ______________

ADDRESS: ____ CITY: ___________________________________

STATE: ______________ ZIP CODE: ______________ EMAIL: ____

PHONE NUMBER: (CELL) _____________________ (WORK) _____________________ (HOME) _____________________

OCCUPATION: ____ EMPLOYER: ____________________________________

PRIMARY CARE PHYSICIAN: _____________________________________ LOCATION: _____________________________

PREFERRED PHARMACY: _______________________________________ LOCATION: _____________________________

EMERGENCY CONTACT NAME: __________________________________ RELATIONSHIP: __________________________

EMERGENCY CONTACT PHONE NUMBERS: ____

HEIGHT: _________ WEIGHT: _________ DECLINE WEIGHT ____

DO YOU USE TOBACCO PRODUCTS? YES / NO / NEVER / FORMER USE

IF YES, HOW OFTEN? ___EVERDAY ___SOME DAYS ___DECLINE

IF YES, WHAT KIND? ___CIGARETTES ___CIGARS ___PIPE ___OTHER

DO YOU DRINK ALCOHOL? YES / NO

OCULAR HISTORY

DO YOU WEAR GLASSES? YES / NO

DO YOU WEAR CONTACT LENSES? YES / NO IF YES, WHAT TYPE? ____

PLEASE LIST ANY PAST OR PRESENT EYE DISEASES, EYE INJURIES, OR EYE SURGERIES AND YEAR: ______________________

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I acknowledge that I have received/reviewed a copy of Portland Eye Care's Notice of Privacy Practices. I know that at anytime I can request my own personal copy of the form as well as find it on the office website. I authorize doctors and staff to disclose information regarding my medical treatment, diagnosis, and any information regarding my financial account with the following designated individuals:

(NAME/RELATION) _________________________________ (NAME/RELATION) __________________________________

(NAME/RELATION) _________________________________ (NAME/RELATION) __________________________________

I have read and understand the HIPAA guidelines.

_____________________________ _____________________________ _____________________

SIGNATURE OF PATIENT/GUARDIAN RELATIONSHIP IF NOT PATIENT DATE