**Nelson Eye Associates**

## PATIENT INFORMATION

Name:_____

Address: _____

City: _____State _____

Zip Code: _____

Home Phone: _____

Cell Phone: _____

Email Address: _____

Date of Birth: _____

Occupation: _____

Primary Care Physician: _____

Who referred you to our office? _____

## VISION INSURANCE

Insurance Company: _____

Insurance ID# _____

Name of Insured: _____

Relationship to Insured Self Spouse Child Other

Insured's DOB: _____

Insured's Address: _____

Insured's Phone: _____

## PRIMARY MEDICAL INSURANCE

Insurance Company: _____

Insurance ID# _____

Name of Insured: _____

Relationship to Insured Self Spouse Child Other

Insured's DOB: _____

Insured's Address: _____

Insured's Phone: _____

## SECONDARY MEDICAL INSURANCE

Insurance Company: _____

Insurance ID# _____

Name of Insured: _____

Relationship to Insured Self Spouse Child Other

Insured's DOB: _____

Insured's Address: _____

Insured's Phone: _____

I authorize the release of any medical or other information to process this claim. I also request payment of insurance medical benefits either to Marc B. Nelson, O.D. or Nelson Eye Associates, P.C., who accepts assignment for services provided. I understand that I am responsible for all charges not covered by my insurance. I acknowledge that I have received the Notice of Privacy Practices of Nelson Eye Associates.

_____

Signature of Patient (or guardian if minor)

**Patient History Questionnaire**

**NELSON EYE ASSOCIATES. P.C.**

Patient Name:_____

## Please circle all that apply:

**Primary reason for today's visit**:

Yearly health exam
Contact lens exam
Eyeglasses exam
Eye infection/problem
Lasik evaluation

**Eye Information**

Do you presently have any problems with the following?

Blurred distance vision
Blurred near vision
Eye strain with computer use
Itching/burning/discharge
Watery eyes
Eye pain
Double vision
Glare/light sensitivity/ halos
Floaters
Flashes of light
Problems with night vision/driving

Do you currently wear glasses?

Do currently wear contact lenses?

Have you ever had an eye injury disease or operation? If so please indicate: _____

Have you ever been told you have any of the following?

Glaucoma
High eye pressure
Cataracts
Macular degeneration
Retinal holes/tears/degeneration
Keratoconus

Any other problem not listed: _____

Do you?

Smoke ____/day
Drink alcohol _____/day
If female are you pregnant or nursing?

Do you suffer from seasonal or environmental allergies?

**Medical Information**

Do you have any of the following?

High blood pressure
Heart disease
Diabetes (Type I /Type II)
High cholesterol
Asthma
Migraines/headaches
Arthritis or Lupus
MS
HIV
Cancer

Other (please describe): _____

Do you have problems with any of these systems?

Nervous
Mental
Respiratory (lungs/breathing)
Gastrointestinal (stomach/intestines)
Musculoskeletal (muscles/joints)
Genitourinary (genitals/kidney/bladder)
Endocrine (hormones/glands/thyroid)
Hematology (blood/lymph)
Integument (skin)
Ears/Nose/Throat
Cardiovascular (heart/blood vessels)

CURRENT MEDICATIONS:_____

_____

Surgeries: _____

Are you allergic to any medications
If so please list: _____

Does any one in you family have any of the following conditions?

High blood pressure
Heart disease
Diabetes
Cancer
Glaucoma
Cataracts
Macular degeneration
Retinal problems
Blindness

Other: _____

Office use only:
Reviewed by: _____ Date: _____