William Murray, O.D. Monica Chitkara, O.D.

PATIENT INFORMATION FORM

This information is used exclusively to help us provide the highest quality of professional services and ophthalmic products for your personal needs.

- Family doctor: _____ Phone: ( )_____
- Other doctor(s)*: _____ Phone: ( )_____

** Any other doctor(s) you see and with whom you would like us to share your visit information*

Last Name: _____ First Name: _____ M.I. _____

Date of Birth: ____/____/____ Gender: Male ☐ Female ☐ SSN: ____-____-____

Phone: Home: ( )_____ Daytime: ( )_____ Cell: ( )_____

May we leave a voicemail at the above numbers: Yes _____ No _____

Street Address: _____ City: _____ State: _____ Zip: _____

Patient's Employer: _____ Occupation: _____

Policyholder: _____ Date of Birth: _____ Employer: _____

Emergency Contact: _____ Relationship: _____

Telephone #: ( )_____ Are we able to leave messages with this person? Yes ☐ No ☐

Please list family members or persons we may talk to about your vision/medical information:

_____

Vision Insurance Company: _____ Medical Insurance Company: _____

Email Address: _____

How did you hear about our office? _____

Please initial before each paragraph to indicate your agreement to it and sign below:

X ____State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this notice. We must follow the privacy practices as described in Drs McClurg & Murray's notice of privacy practices. This notice takes effect September 23, 2013 and will remain in effect until it is amended or replaced by us. It is our right to change our privacy practices provided the law permits the changes. Before we make significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date the changes were made.

You may request a copy of our Privacy Notice at any time by contacting our office. All information about how your medical information may be used is described in this notice. By signing this form, you have acknowledged our Privacy Practices and that a copy of the Drs McClurg & Murray, LLC Notice of Privacy Practices has been made available to you.

Drs McClurg & Murray, LLC is required by law to maintain the privacy of our patients' health information. Unless you have signed a form authorizing the use or disclosure, we will not disclose your health information for any purpose other than Drs McClurg & Murray, LLC role in the treatment, payment, or for health care operations. With your signature below, we may disclose your health information to others, including designated family members, friends, or others who are involved in your health care or in payment for your healthcare.

X____My signature below authorizes third party payment of medical benefits to be made to Drs McClurg & Murray, LLC. I understand that authorizations obtained prior to claim submissions do not guarantee payment by the insurance company. Drs McClurg & Murray, LLC will submit insurance claims on my behalf and will forward a statement to me based on the explanation of benefits received from my insurance company. I understand that I am responsible for all payments due after receipt of the explanation of benefits.

Signature: _____ Date: _____

Medical Health Questionnaire

Name_____ DOB_____ Date_____

Constitution
- ☐ Cancer
- ☐ Develop Disabilities
- ☐ Fatigue

Other_____

ENT
- ☐ Dry Mouth
- ☐ Hearing Loss
- ☐ Laryngitis
- ☐ Sinusitis

Other_____

Neuro
- ☐ Cerebral Palsy
- ☐ Epilepsy
- ☐ Migraine
- ☐ Multiple Sclerosis
- ☐ Stroke/Cva
- ☐ Tumor

Other_____

Psychiatric
- ☐ Anxiety Disorder
- ☐ Attention Deficit
- ☐ Bipolar Disorder
- ☐ Depression

Other_____

Cardiovascular
- ☐ ~~Congestive~~ Heart Failure
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Stroke/Cva
- ☐ Vascular Disease

Other_____

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Chronic Obstruction
- ☐ Emphysema
- ☐ Sleep Apnea

Other_____

Gastrointestinal
- ☐ Acid Reflux
- ☐ Celiac Disease
- ☐ Crohn's Disease
- ☐ Colitis

Other_____

Genitourinary
- ☐ Benign Prostate Hypertrophy
- ☐ Chlamydia
- ☐ Herpes
- ☐ Kidney Disease
- ☐ Nursing
- ☐ Pregnant
- ☐ Prostate Disease/Cancer

Other_____

Musculoskeletal
- ☐ Ankylosing Spondylitis
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Muscular Dystrophy
- ☐ Osteoarthritis
- ☐ Osteoporosis

Other_____

Integumentary
- ☐ Eczema
- ☐ Herpes Simplex/cold Sores
- ☐ Herpes Zoster/Shingles
- ☐ Psoriasis
- ☐ Rosacea

Other_____

Hematologic/Lymphatic
- ☐ Anemia
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ High Cholesterol
- ☐ Large Volume Blood Loss
- ☐ Ulcer

Other_____

Allergic/Immune
- ☐ Drug Allergies
- ☐ Environmental Allergies
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Sjogrens Syndrome

Other_____

Medications and Dosage

_____
_____
_____
_____
_____
_____
_____

Please complete reverse side

	FATHER	MOTHER	BROTHER	SISTER	SON	DAUGHTER	UNKNOWN
CANCER (If yes please indicate type in comments below)	☐	☐	☐	☐	☐	☐	☐
TYPE 1 DIABETES	☐	☐	☐	☐	☐	☐	☐
TYPE 2 DIABETES	☐	☐	☐	☐	☐	☐	☐
HYPERTENSION	☐	☐	☐	☐	☐	☐	☐
HYPERTHYROIDISM	☐	☐	☐	☐	☐	☐	☐
HYPOTHYROIDISM	☐	☐	☐	☐	☐	☐	☐
CATARACT	☐	☐	☐	☐	☐	☐	☐
MACULAR DEGENERATION	☐	☐	☐	☐	☐	☐	☐
GLAUCOMA	☐	☐	☐	☐	☐	☐	☐

Family Health Comments:_____

Preferred Language: English ☐ Spanish ☐ French ☐ Other:_____

Race: Asian ☐ Black or African American ☐ White ☐ Pacific Islander / Hawaiian ☐ American Indian ☐ Alaska Native ☐ Unknown ☐ Other: _____

Ethnicity: Hispanic or Latino ☐ Non-Hispanic or Latino ☐