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