OFFICE OF PECOS T. OLURIN M.D.

1403 NORTH RODNEY STREET
WILMINGTON, DE 19806
PHONE 302.654.4800 FAX 302.984.0440

OPHTHALMIC HISTORY FORM

PLEASE COOPERATE WITH OUR EFFORTS TO BETTER SERVE YOU BY COMPLETING THIS FORM AS ACCURATELY AS POSSIBLE.

Name _____ : Date of Birth _____ Age _____

List the problems that are the reason for this visit including associated non- eye related problems

_____

_____

_____

Date of last eye exam: _____ Do you wear glasses? YES ☐ No ☐ Do you wear contacts? YES ☐ No ☐

How old is your current prescription? _____What is your contact lens replacement regimen? _____

Medication Please list all medications that you are on at this time.

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergies: Please list all known and suspected allergies, especially to medicines:

_____ _____

_____ _____

_____ _____

Past Medical History: Please check all that apply to you or blood related family members:

	(PATIENT) YES	(PATIENT) NO	(FAMILY) Family History		(PATIENT) YES	(PATIENT) NO	(FAMILY) Family History
Eye Injury	☐	☐	☐	Seizures	☐	☐	☐
Lazy Eye	☐	☐	☐	HIV/AIDS	☐	☐	☐
Glaucoma	☐	☐	☐	Heart Disease	☐	☐	☐
Diabetes	☐	☐	☐	Obesity	☐	☐	☐
Hypertension	☐	☐	☐	Liver Disease	☐	☐	☐
Cataracts	☐	☐	☐	Lupus	☐	☐	☐
Stroke	☐	☐	☐	Alcoholism	☐	☐	☐
Bleeding Problems	☐	☐	☐	Migraines	☐	☐	☐
Thyroid Disease	☐	☐	☐	Irregular heart beat	☐	☐	☐
Cancer	☐	☐	☐	Blood Transfusions	☐	☐	☐
Arthritis (Rheumatoid)	☐	☐	☐	Sarcoidosis	☐	☐	☐
Kidney Disease	☐	☐	☐	Tuberculosis	☐	☐	☐
Asthma/Emphysema	☐	☐	☐	Lyme disease	☐	☐	☐

Please describe any pertinent medical issues that you think are relevant (INCLUDE ALL PAST SURGERIES)

_____

_____

_____

Do you currently smoke? YES ☐ No ☐ Do you drink alcohol regularly YES ☐ No ☐

Do you use now or have you used recreational drugs in the past (particularly IV drug use YES ☐ No ☐

REVIEWED BY PECOS T. OLURIN MD _____

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PATIENT REGISTRATION ENTRY FORM

Pease print all information (complete/mark as appropriate)

Who is your primary care physician: _____? Is the office aware of this appointment Y ☐ N ☐

Name: _____-_____-____ Sex M ☐ F ☐ Social Security #_____-_____-_____

Address: _____ Date of birth: _____-_____-_____ Age_____

City, State, Zip: _____-_____-_____ marital status Single ☐ Married ☐ Divorced ☐ Widowed ☐

Home phone: (_____) _____Work phone: (_____) _____ ext._____ Cell Phone: _____

E-mail address: _____ Occupation: _____

Employer address: _____

Next of kin: _____ Next of kin contact #_____ _____

Who referred you to us: Insurance ☐ Family ☐ Friend ☐ Primary Doctor ☐ Emergency room ☐ Urgent visit Center ☐ Other ☐

INSURANCE INFORMATION FILL THIS PORTION OR GIVE THE RECEPTIONIST YOUR CARD

Person responsible for bill: _____ Contact Phone number

Primary Insurance:_____

ID# _____ Group# _____

Address: _____ City, State, And Zip:

_____

Phone number: (_____) _____Subscriber's name: _____

Subscriber's employer: _____

Subscriber's relationship to patient: _____

Subscriber's birth date: _____/_____/_____

SECONDARY INSURANCE (FILL ONLY IF YOU HAVE A SECOND INSURANCE COVERAGE)

ID# _____ Group# _____

Address: _____ City, State, And Zip: _____

Phone number: (_____) _____Subscriber's name: _____

Subscriber's employer: _____Subscriber's relationship to patient: _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependant) have insurance coverage with_____ and assign directly to Dr Pecos T. Olurin all insurance benefits, if any, other payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

SIGNATURE OF RESPONSIBLE PARTY OR PATIENT DATE