BROOKSVILLE EYE CENTER
PATIENT INFORMATION

DATE _____

NAME: _____ **SEX:** ____ **AGE:** _____ **DOB:** _____

PRESENT ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

HOME PHONE: _____ **EMAIL:** _____

CELL PHONE: _____ **SINGLE**___ **MARRIED:** ____ **WIDOWED:** _____

PREFERRED METHOD OF COMMUNICATION: HOME_____ **CELL**____ **EMAIL**____

RACE: WHITE ___ **BLACK** ___ **AMER INDIAN** ___ **HISPAN** ___ **ASIAN**___ **OTHER**_____

SOCIAL SECURITY NO: _____ **SPOUSE/PARENT NAME**_____

WORK INFORMATION

EMPLOYER: _____ **PHONE:** _____
EMPLOYERS ADDRESS: _____
CITY: _____ **STATE:** _____ **ZIP CODE:** _____

INSURANCE INFORMATION

VISION INSURANCE: _____
POLICY HOLDER NAME: _____
POLICY HOLDER DATE OF BIRTH: _____ **MEMBER ID:** _____

PRIMARY INSURANCE: _____
POLICY HOLDER NAME: _____ **MEMBER ID:** _____
POLICY HOLDER DATE OF BIRTH: _____ **SOCIAL SECURITY NO:** _____

SECONDARY INS. CO.: _____
POLICY HOLDER NAME: _____ **MEMBER ID:** _____
POLICY HOLDER DATE OF BIRTH: _____ **SOCIAL SECURITY NO.:** _____

REFERRAL INFORMATION

HOW WERE YOU REFERRED TO BROOKSVILLE EYE CENTER:
FRIEND/FAMILY: _____
PHONE BOOK: _____
OTHER: _____

NAME OF FAMILY PHYSICIAN: _____

← *OVER* →

MEDICAL HISTORY
DO YOU HAVE ANY OF THE FOLLOWING PROMBLEMS?

	YES	NO		YES	NO
DIABETES TYPE ___	___	___	HEART DISEASE	___	___
HIGH BLOOD PRESSURE	___	___	CANCER	___	___
EMPHYSEMA	___	___	EPILEPSY	___	___
BLEEDING TENDENCIES	___	___	ASTHMA	___	___
SHORTNESS OF BREATH	___	___	HEPATITIS	___	___
NERVOUS DISORDER	___	___	HIV	___	___
THYROID	___	___	CHOLESTEROL	___	___
CURRENT SMOKE	___	___	DO YOU DRINK		
PREVIOUS SMOKER	___	___	ALCOHOL?	___	___

OTHER CONDITIONS:_____

_____

HAVE YOU HAD ANY PREVIOUS SURGERY? **YES** ___ **NO** ___
If yes, what type? _____

_____

HAVE YOU HAD ANY PREVIOUS PROBLEMS WITH YOUR EYES?
YES ___ **NO** ___
If yes, what type of problem? _____

_____

HAVE YOU HAD ANY EYE SURGERY? **YES** ___ **NO** ___
If yes, list type _____

_____

FAMILY HISTORY OF: (circle all that applies), MACULAR DEGENERATION, CATARACTS, GLAUCOMA, DIABETES, HYPERTENTION
OTHER_____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? **YES** ___ **NO** ___
If yes, list: _____

ARE YOU PRESENTLY ON ANY MEDICATIONS? **YES** ___ **NO** ___
If yes, list medication and dosage:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

I acknowledge that I received a copy of Dr. Jay B. Klein OD PA Notice Of Privacy Practices

PATIENT'S SIGNATURE: _____