

Doctor: _____

PATIENT INFORMATION

Name: _____ Patient ID #: _____ Sex: []M []F
Address: _____ Date of Birth: _____ Age: _____
City, State, Zip: _____ Driver's License #: _____
Primary Phone: () _____ Social Security #: _____
Alt Phone: _____ Marital Status: []Married []Single []Divorced
Mobile/Pager Phone: _____ Referring Physician: _____
Primary Physician: _____

PATIENT EMPLOYMENT INFORMATION

[]Employed []Retired []Unemployed [X]Other
Employer's Name: _____
Employer's Phone: _____
Occupation: _____

EMERGENCY CONTACTS

Name	Relationship	Phone
_____	_____	_____
_____	_____	_____

RESPONSIBLE PARTY (if patient is under 18 years of age)

Name: _____ Employer: _____
Address: _____ Home Phone: _____
City, State, Zip: _____ Work Phone: _____
SSN: _____
Date of Birth: _____

PRIMARY INSURANCE

Insurance Company Name: _____
ID #: _____
Group/Policy #: _____
Subscriber's Name: _____
Subscriber's Phone #: _____
Relationship to Patient: _____
Subscriber's Employer: _____
Subscriber's SS #: _____
Subscriber's Date of Birth: _____

SECONDARY INSURANCE

Insurance Company Name: _____
ID #: _____
Group/Policy #: _____
Subscriber's Name: _____
Subscriber's Phone #: _____
Relationship to Patient: _____
Subscriber's Employer: _____
Subscriber's SS #: _____
Subscriber's Date of Birth: _____

WORK RELATED INJURY

Only applicable if injury is related to work or auto accident

Insurance Carrier Name: _____ Address: _____
City, State, & Zip: _____ Phone: _____
Claim Number: _____ Date of Injury: _____ Employer @
time of Injury: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

(Please read and sign)

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to the doctor, and authorize him/her to furnish information regarding my illness to my insurance carrier. *I understand that I am responsible for any amount not paid for by my insurance.*

PATIENT/GUARDIAN SIGNATURE

DATE

CHILDREN'S EYE CARE HEALTH HISTORY FORM

Patient Name: _____ Date: _____

Reason For Visit: _____

Referring Dr: _____ Primary Care Dr: _____

Eye History (Circle or list previous ocular problems)

Lazy eye (amblyopia) / strabismus / trauma / cataracts / near sighted / far sighted / astigmatism

Please list all previous eye surgeries and dates:

Family Ocular History

lazy eye / strabismus / glaucoma / retinal problems / diabetic retinopathy / graves disease / macular degeneration

Family Medical History

seizures / migraine / high blood pressure / heart Disease / asthma / thyroid / diabetes / arthritis / cancer / Other:

MEDICAL HISTORY

Medications _____

Allergies to Medications _____

Any previous surgeries? Yes No _____

Birth History (if < 5yrs) Birth Weight: _____ lbs oz Weeks Gestation _____

Was the baby on oxygen? Yes No If yes, how long? _____

Social History Child

Patient is : Living with parent(s) Adopted

Any learning disabilities? Yes No

Other family members seen in office: _____

Social History Adult

smoke Yes No

drink Yes No

MEDICAL HISTORY	Yes	No	If yes, please explain
General health (eg, cold, fever, weight loss, weight gain)			
Skin problems (eg, rash, hives eczema, birth marks, tumors, itching)			
Ear/Nose/Throat (eg, sinus problems, ear infections, hearing loss, sore throat)			
Respiratory problems (eg, wheezing, cough, asthma, shortness of breath)			
Heart problems (eg, high blood pressure, heart murmur, irregular heart beats)			
Gastrointestinal (eg, acid reflux, constipation, diarrhea, abdominal pain)			
Genitourinary kidney problems, bladder problems, UTI			
Musculoskeletal (eg, gross or fine motor delays, arthritis, muscle weakness)			
Neurological (eg, seizures, headaches, vertigo, head trauma, cerebral palsy)			
Psychiatric (eg, ADD, ADHD, anxiety, depression, behavioral problems)			
Endocrine (eg, insulin dependent diabetes, thyroid, hormone imbalance)			
Hemato/lymphatic (eg, easy bleeding, easy bruising, swollen lymph nodes)			
Other (eg, Trisomy 21, autism)			