New Patient Information

PLEASE PRINT USING BLACK INK ONLY

Name _____ Date _____

Address _____
(Street) (City) (State) (zip)

Date of Birth _____ Age _____ ☐ Male ☐ Female

Social Security # _____ Phone (Home) _____

Occupation _____ (Work) _____

Employer _____ (Cell) _____

Email address _____

Who referred you to our office? _____

Please check one: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Name of Spouse _____ Telephone _____

Date of Birth _____ Employer _____

Whom to notify in emergency (nearest relative):

Name _____ Relationship _____

Phone _____ Alternate Phone _____

Address _____

Complete if under 18 years of age:

Father's Name _____ Employer _____

Phone/Address (if different) _____

Mother's Name _____ Employer _____

Phone/Address (if different) _____

I authorize the disclosure of my health and medical information to the following people. The authorization will be effective until I revoke this authorization.

_____

_____

Authorization to release

I hereby authorize the doctor to furnish the insured's insurance company all information which said insurance company may request concerning my present claim.

Assignment of insurance benefits

I hereby assign to the doctor all money to which I am entitled for expense relative to the services performed from time to time, but not to exceed my indebtedness to said doctor. It is understood that any money received from the above named insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand I am financially responsible to said doctor for charges.

I acknowledge that I have been presented a copy of this office's Notice of Privacy Practices and that all of the information provided on this form is correct to the best of my knowledge.

_____ _____

Signature of Patient or Responsible Party Date

Medical History

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Name _____

Primary Care Physician _____PCP Phone _____

What concerns, if any, do you have about your eyes? _____

_____

Have you ever had eye surgery? ☐ Yes ☐ No
If yes, please describe: _____

Have you ever had an eye injury? ☐ Yes ☐ No
If yes, please describe: _____

Do you have an optometrist? ☐ Yes ☐ No If yes, please list: _____
Do you wear glasses or contact lenses? ☐ Yes ☐ No If yes, for how long? _____

List all drug allergies _____

List all medications _____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Please indicate whether you yourself (mark "S" for self) or any blood relatives ("R") have any of the following:

____ heart disease
____ high blood pressure
____ high cholesterol
____ diabetes
____ other (please list)

____ arthritis
____ thyroid disease
____ stroke
____ cancer

____ glaucoma
____ blindness
____ retinal detachment
____ macular degeneration

_____
_____

Please list all surgical procedures you have had:

_____
_____

Do you smoke? ☐ Yes ☐ No Smoked previously? ❑ Yes ❑ No
Are you pregnant? ☐ Yes ☐ No
Do you use alcohol? ☐ Yes ☐ No If yes, how often? _____

_____ _____
Signature of patient or Responsible party Date