

New Patient Information

PERSONAL INFORMATION (Please Print)

Patient Name _____

Phone # _____ Cell Phone# _____

Date of Birth _____ Age _____ Gender _____ SS# _____

Address _____

Marital Status: Single Married Widowed Divorced

Employer _____ Phone _____

Address _____

Spouse Name _____ Date of Birth _____

SS# _____ Employer _____

Employer Address _____ Phone _____

Complete if under 18 years or a student

Name of Father _____ Employer _____

Address _____ Phone _____

Name of Mother _____ Employer _____

Address _____ Phone _____

INSURANCE INFORMATION

Primary Insurance _____ Referral Required? YES NO

Policy Holder _____ Date of Birth _____

SS# _____ Relation _____

Secondary Insurance _____ Referral Required? YES NO

Policy Holder _____ Date of Birth _____

SS# _____ Relation _____

EMERGENCY INFORMATION

Who to notify in emergency (nearest relative or friend)?

Name _____ Phone _____ Relation _____

WHO REFERRED YOU TO OUR PRACTICE?

Doctor _____ Yellow Pages Newspaper Television

Friend/Relative _____ Other _____

Name _____ Date _____ Primary Care Doctor _____

Review of Systems

Do you have a problem with any of the following? If yes, please circle all that apply:

- Constitutional _____ Yes No Weight Loss/Gain, Fever
- Ear, Nose, Throat, Mouth _____ Yes No Sinus
- Cardiovascular _____ Yes No Heart, High Blood Pressure
- Respiratory _____ Yes No Lung, Breathing, Asthma, TB
- Gastrointestinal _____ Yes No Stomach, Intestines, Hepatitis
- Genitourinary _____ Yes No Genital, Kidneys, Bladder
- Musculoskeletal _____ Yes No Arthritis, Muscle, Joints
- Integumentary _____ Yes No Skin
- Neurological/Psychiatric _____ Yes No Depression, Nerves, MS
- Endocrine _____ Yes No Diabetes, Thyroid
- Hematologic/Lymphatic _____ Yes No Anemia, Bleeding Tendencies
- Allergic/Immunologic _____ Yes No Lupus, Sjogrens, HIV
- Other _____ Yes No Cancer, Stroke, etc.

Please list all medications you are currently taking including eye medication: _____

Please list any allergies to medication(s) _____

Ocular History

Have you ever been diagnosed with any of the following?

- Cataracts _____ Yes No Cornea disease _____ Yes No
- Retina/Macular disease _____ Yes No Glaucoma _____ Yes No
- Crossed eyes _____ Yes No Other eye disorders _____ Yes No

Eye Surgeries: _____

Eye Injuries: _____

Family and Social History

Do any of your family members have the following?

- Glaucoma _____ Yes No Diabetes _____ Yes No
- Cataracts _____ Yes No Heart problems _____ Yes No
- Retinal/Macular disease _____ Yes No Stroke _____ Yes No
- Retinal Detachment _____ Yes No Cancer _____ Yes No

Current Occupation _____

Do you smoke? Yes No Do you drink alcohol? Yes No