New Patient Information

Personal Information (Please Print)

Name _____ Date _____

Date of Birth _____ Age_____ M/F_____ Soc Security #_____

Home Address _____

_____ Email Address_____

Home Phone ( ) _____ Cell Phone ( ) _____

Occupation _____ Employer _____

Work Address _____ Work Phone ( ) _____

Martial Status Single___ Married ____ Divorced ____ Widowed _____

Spouse's Name _____ Spouse's Employer _____

Address _____ Phone ( ) _____

Referred by: Doctor _____ Friend/Relative _____

Yellow Pages _____ Newspaper _____ Other _____

Person to notify in case of emergency _____

Relationship _____ Phone ( ) _____

Complete if under 18 years of age or a student

Name of Father _____ Employer _____

Address _____ Phone ( ) _____

Name of Mother _____ Employer _____

Address _____ Phone ( ) _____

Insurance Information (Please have the insurance card available for photocopy)

Medicare # _____ Name/Address 2nd Insurance _____

Medical Insurance _____ Group # _____ ID# _____

Workers Comp Carrier and Address _____

Pharmacy - Name _____ Address _____

Financial Assignment and Agreement of Privacy Notice

1. Insurance is considered a method of reimbursing the patient for fees to the doctor and is not a substitute for payment. Some insurance companies pay fixed amounts and others pay a percentage of the charge. It is my responsibility to pay any deductible amount, co-insurance or any other balance not paid by my insurance. I understand that I am financially responsible for all charges whether or not paid by said insurance.
2. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information about me to release to Health Care Financing Administration, its agents or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
3. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.
4. I have been provided with Notice of Privacy Practices that gives a description of my privacy right and information uses and disclosures. I understand that I can review the notice prior to signing this acknowledgement. I understand that the organization reserves the right to change their notice and practices.

Signed (Patient or parent if Minor) _____ Date _____

Patient History Record

Name: _____ **Date**: _____

Please answer the following questions about your medical status and history:

- Have you ever been treated for any medical conditions: No ____ Yes_____ (if yes please explain)
  _____
- Have you ever had any eye disease or surgery? No ____ Yes_____ (if yes please explain)
  _____
- Have you ever had any surgery? No ____ Yes_____ (if yes please explain)
  _____
- Have you ever been hospitalized? No ____ Yes_____ (if yes please provide date and reason)
  _____
- Do you take any medications: No ____ Yes_____ (if yes please list)
  _____
- Do you take any eye medications: No ____ Yes_____ (if yes please list)
  _____
- Do you have any drug allergies? No ____ Yes_____ (if yes please list)
  _____

Review of Systems:	**No**	**If Yes, Please Explain:**
Chronic fever, unexplained weight loss/gain/fatigue	___	_____
Hearing loss, sinus problems, sore throat	___	_____
Chest pain, irregular heart beat	___	_____
Shortness of breath, wheezing, coughing	___	_____
Heartburn, abdominal pain, diarrhea, vomiting	___	_____
Blood in urine, kidney stone	___	_____
Rashes, excessive dryness	___	_____
Muscle aches, joint pain, swollen joints	___	_____
Numbness, weakness, headaches, paralysis	___	_____
Depression, anxiety	___	_____
Venereal diseases, HIV, AIDS	___	_____

- Do any medical or eye diseases run in your family? No ____ Yes_____ (if yes please explain)
  _____
- Do you smoke? Yes____ No_____ Do you drink alcohol? Yes____ No_____
- Education: _____ Occupation: _____

Doctor's Signature: _____ Date: _____

Review and Update:

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