PATIENT INFORMATION

PERSONAL INFORMATION

NAME:_____ BIRTH DATE:____ / ____ / ____

ADDRESS: _____

CITY:_____ ST:_____ ZIP:_____ PHONE (Home)_____

AGE:____ SEX: M / F SOCIAL SECURITY #:_____(Cell)_____

____Mr. ____Mrs. ____Ms. ____Dr. ____Single ____Married ____Widowed ____Divorced

EMAIL ADDRESS: _____

OCCUPATION:_____ EMPLOYER:_____

EMPLOYER ADDRESS:_____ EMPLOYER PHONE #:_____

SPOUSE'S NAME:_____ SPOUSE'S EMPLOYER _____

WHOM TO NOTIFY IN CASE OF EMERGENCY (NEAREST RELATIVE)

NAME:_____ RELATIONSHIP:_____ PHONE(DAY)_____ (EVE)_____

PLEASE COMPLETE IF UNDER AGE 18 OR A STUDENT:

FATHER'S NAME:_____ FATHER'S EMPLOYER:_____

FATHER'S ADDRESS:_____ FATHER'S PHONE: _____

MOTHER'S NAME:_____ MOTHER'S EMPLOYER:_____

MOTHER'S ADDRESS:_____ MOTHER'S PHONE:_____

REFERRAL SOURCE- HOW DID YOU HEAR ABOUT EYE DOCTORS OF LANCASTER? (CIRCLE)

Doctor Emergency Room Relative Friend Yellow Pages OTHER_____

WHO SENT YOU TO EYE DOCTORS OF LANCASTER FOR THIS APPOINTMENT? (CIRCLE)

Family Doctor Eye Doctor Workman's Comp Emergency Room OTHER_____

THEIR NAME AND ADDRESS:_____

_____

NAME & ADDRESS OF FAMILY PHYSICIAN:_____

_____

BILLING INFORMATION (insurance card is required at time of check-in)

NAME OF YOUR PRIMARY MEDICAL INSURANCE CO:_____

NAME OF INSURED:_____ INSURED'S DATE OF BIRTH:_____

SOC. SEC. # OF INSURED:_____ INSURED'S EMPLOYER:_____

RELATIONSHIP TO INSURED: _____ GROUP #:_____

POLICY / MEMBER #:_____ EFFECTIVE DATE OF COVERAGE:_____

WORKMENS COMPENSATION (JOB INJURY) TO WHOM IS BILL SENT? _____

_____

IF YOU HAVE ANY OTHER MEDICAL INSURANCE, PLEASE LIST INFORMATION ON BACK OF FORM.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize *Eye Doctors of Lancaster* to furnish information to my INSURANCE CARRIER, EMPLOYER, REFERRING PHYSICIAN, or OTHER PHYSICIANS concerning my treatment and/or illness.

ASSIGNMENT OF INSURANCE BENEFITS/BILLING POLICY

I transfer assignment of INSURANCE BENEFITS to *Eye Doctors of Lancaster* for services, treatment, supplies, and/or surgeries provided by physicians of staff in employment of this practice.

I understand that I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE.

I understand that if I do not have insurance, PAYMENT IS DUE AT THE TIME OF SERVICE.

_____ _____

PATIENT SIGNATURE RESPONSIBLE PARTY SIGNATURE

_____

DATE

MEDICAL INFORMATION FORM

MR / MRS / MS / DR_____ **BIRTH DATE:** ___ / ___ / ___

AGE: _____ **SEX: M F**

WHAT BRINGS YOU TO OUR PRACTICE TODAY? _____

WHEN WAS YOUR LAST EYE EXAM? _____ WHERE? _____

DO YOU WEAR GLASSES? YES NO IF YES, SINCE WHAT AGE? _____

DO YOU WEAR CONTACT LENSES? YES NO IF YES, WHAT TYPE? _____

PLEASE CHECK WHICH OF THE FOLLOWING APPLY TO YOU AND THE DATE IT FIRST OCCURRED:

MEDICAL PROBLEMS	NO	YES	DATE
ALZHEIMER'S			
ARTHRITIS			
ASTHMA / COPD / BRONCHITIS			
BLOOD DISORDERS (TYPE)			
BLOOD TRANSFUSION			
BOWEL DISORDERS			
CANCER (TYPE)			
DIABETES (TYPE)			
HIGH BLOOD PRESSURE			
HEPATITIS / JAUNDICE			
HEART DISEASE			
HEAD INJURY			
HIV POSITIVE / AIDS			
KIDNEY DISEASE			
LOSS OF CONSCIOUSNESS			
LUPUS			
MIGRAINE HEADACHES			
NERVOUS DISORDER			
PSORIASIS			
RAYNAUD'S DISEASE			
RHEUMATIC FEVER			
SARCOIDOSIS			
SEIZURES			
SHOCK			
STROKE			
SYPHILIS / GONORRHEA / VD			
THYROID DISEASE			
TUBERCULOSIS			

EYE PROBLEMS	NO	YES	DATE
AMBLYOPIA / LAZY EYE			
CATARACTS			
CORNEAL DISEASE			
EYE INJURY			
DIABETIC RETINOPATHY			
GLAUCOMA			
HERPES - EYES / EYELIDS			
MACULAR DEGENERATION			
RETINAL DETACHMENT			
STRABISMUS / CROSSED EYE			

FAMILY MEDICAL PROBLEMS:

Do any family members have:	NO	YES	RELATIVE
GLAUCOMA			
MACULAR DEGENERATION			
DIABETES			
RETINAL DETACHMENT			
CATARACTS			
AMBLYOPIA or STRABISMUS			
OTHER (list):			

_____

_____

_____

_____

_____

_____

_____

OTHER MEDICAL PROBLEMS:

_____

_____

_____

PERSONAL HISTORY:

Weight:_____ Height:_____

Are you pregnant ? YES NO

Language? English Spanish Other_____

Race: Asian Black/AfricanAmer White Other_____

Ethnicity: Not Hispanic/Latino Hispanic/Latino

SOCIAL HISTORY:

	YES	NO
DO YOU SMOKE?		
DO YOU USE IV DRUGS?		
DO YOU DRINK ALCOHOL?		

ALLERGIES:

ARE YOU ALLERGIC TO?	YES	NO
ASPIRIN		
CODEINE		
DEMEROL		
IODINE		
LOCAL ANESTHETIC		
PENICILLIN		
SULFA		

OTHER (Please List):_____

_____

_____

IF YES, Please Describe Reaction:

_____

HAVE YOU HAD EYE SURGERY? **YES NO**

PLEASE LIST (including laser and lid surgery):

SURGERY DATE SURGEON/HOSPITAL

_____

_____

_____

HAVE YOU HAD GENERAL SURGERY? **YES NO**

PLEASE LIST:

SURGERY DATE HOSPITAL

_____

_____

_____

DO YOU TAKE:

	YES	NO
ASPIRIN		
COUMADIN		

MEDICATIONS: (PLEASE LIST)

MEDICATIONS DOSE

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

DO YOU REQUIRE ANTIBIOTICS BEFORE HAVING DENTAL WORK OR SURGERY? **YES NO**

HAVE YOU, OR A FAMILY MEMBER, EVER HAD A SERIOUS REACTION TO GENERAL ANESTHESIA? **YES NO**

IF YES, PLEASE DESCRIBE REACTION:_____

THIS IS TO CERTIFY THAT I, THE UNDERSIGNED, CONSENT TO EXAMINATION AND TREATMENT. THIS INFORMATION AND ANY PHOTOGRAPHY MAY BE USED FOR SCIENTIFIC AND EDUCATIONAL PURPOSES. I HEREBY AUTHORIZE ***EYE DOCTORS OF LANCASTER*** TO FURNISH INFORMATION TO MY INSURANCE CARRIER, EMPLOYER, REFERRING PHYSICIAN, OR OTHER PHYSICIAN CONCERNING MY TREATMENT AND/OR ILLNESS.

NAME _____ DATE _____

DR. SIGNATURE _____ DATE _____

MEDICAL REVIEW OF SYSTEMS

PT. NAME:_____ BIRTHDATE:_____

DO YOU CURRENTLY HAVE ANY PROBLEMS IN THE FOLLOWING AREAS?

	YES	NO
EYES		
Loss of Vision	☐	☐
Loss of Side Vision	☐	☐
Distorted Vision or Halos	☐	☐
Fluctuating Vision	☐	☐
Flashes	☐	☐
Floaters	☐	☐
Eye Pain or Soreness	☐	☐
Light Sensitivity	☐	☐
Double Vision	☐	☐
Crossing or Drifting of Eyes	☐	☐
Redness	☐	☐
Discharge	☐	☐
Foreign Body Sensation	☐	☐
Sandy or Gritty Feeling	☐	☐
Dryness	☐	☐
Itching	☐	☐
Burning	☐	☐
Excess Tearing / Watering	☐	☐
Glare	☐	☐
Styes	☐	☐
CONSTITUTIONAL SYSTEMS		
Fever	☐	☐
Weight Loss or Gain	☐	☐
Fatigue	☐	☐
CARDIOVASCULAR (Heart/Blood Vessels)		
Chest Pain or Palpitations	☐	☐
Other_____	☐	☐
EARS / NOSE / MOUTH / THROAT		
Hearing Difficulty	☐	☐
Ringing or Vertigo	☐	☐
Sinus Congestion	☐	☐
Runny Nose or Post-nasal Drip	☐	☐
Nosebleeds	☐	☐
Dry throat/mouth or Hoarseness	☐	☐
RESPIRATORY (Lungs/Breathing)		
Cough	☐	☐
Shortness of Breath	☐	☐
Wheezing	☐	☐
GASTROINTESTINAL		
Swallowing Difficulty	☐	☐
Vomiting / Heartburn	☐	☐

	YES	NO
GENITO-URINARY		
Urinary Frequency	☐	☐
Urinary Pain or Blood	☐	☐
Males -		
Discharge, Lesions, or Masses	☐	☐
Females -		
Currently Pregnant	☐	☐
Breast Mass or Discharge	☐	☐
Vaginal Bleeding or Discharge	☐	☐
MUSCULOSKELETAL		
Joint Pain, Swelling or Redness	☐	☐
Muscle Pain or Cramps	☐	☐
SKIN		
Rashes or Color Changes	☐	☐
Itching or Dryness	☐	☐
Hair or Nail Changes	☐	☐
NEUROLOGICAL		
Headaches	☐	☐
Numbness or Tingling	☐	☐
Weakness or Paralysis	☐	☐
Fainting or Blackouts	☐	☐
Slurred Speech	☐	☐
PSYCHIATRIC		
Anxiety	☐	☐
Depression	☐	☐
Other_____	☐	☐
ENDOCRINE		
Heat or Cold Intolerance	☐	☐
Excessive Thirst or Hunger	☐	☐
HEMATOLOGICAL / LYMPHATICS / IMMUNOLOGY		
Easy Bruising / Bleeding	☐	☐
Blood Transfusions	☐	☐
Swollen Lymph Nodes	☐	☐

OTHER SYMPTOMS NOT LISTED ABOVE:

_____

_____

_____

_____

_____

_____

TODAY'S DATE:_____