

WELCOME

We are pleased to welcome you to our practice. Please take a few moments to fill out this form as completely as you can.

PATIENT INFORMATION

Today's Date ____/____/____
Patient Name _____
Sex M / F Age ____ Birth date ____/____/____
Social Security # _____
Address _____
City _____
State _____ Zip _____
Cell Phone (____) _____
Home phone (____) _____
Work phone (____) _____
E-mail _____

Patient Occupation: _____
Patient Employer/School _____
Hobbies/Activities _____
Spouse's Name _____
Birth date ____/____/____ SS# _____
If you are a new patient whom may we thank for referring you? _____

OK to TEXT?

Yes No

INSURANCE

Subscriber's Name _____ Relationship to Patient _____
Birth date _____ SS# _____
Insurance Co. _____ ID Number _____

EYE HEALTH HISTORY

Medical Doctor's Name/Clinic _____ Date of last medical exam _____
Name of Eye Doctor/Clinic _____ Date of last eye exam _____
Do you wear glasses? Yes No Do you wear contacts? Yes No Type/Brand _____
Are You interested in any of the following? Eyeglasses: Contact Lenses Vision Correcting Surgery

Place a mark to indicate if you have any of the following:

Blurred vision -Distance	<input type="checkbox"/>	Double vision	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>
Blurred vision -Near	<input type="checkbox"/>	Dry eyes	<input type="checkbox"/>	Macular degeneration	<input type="checkbox"/>
Burning eyes	<input type="checkbox"/>	Eye infection	<input type="checkbox"/>	Itching eyes	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	Eye injury	<input type="checkbox"/>	Peripheral vision loss	<input type="checkbox"/>
Color Vision, Poor	<input type="checkbox"/>	Eye pain	<input type="checkbox"/>	Red Eye(s)	<input type="checkbox"/>
Crossed or "lazy eye"	<input type="checkbox"/>	Floaters or spots	<input type="checkbox"/>	Seeing flashes	<input type="checkbox"/>
Discharge from eyes	<input type="checkbox"/>	Glare / Sensitivity	<input type="checkbox"/>	Watering eyes	<input type="checkbox"/>

Other eye problems or surgeries: _____

Health History

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hay Fever / Pollen allergy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis (Type ____)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes (type 1)	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	S.T.I. (Active)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes (type 2) Adult	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke / CVA	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No

Other medical conditions not noted above _____

Please turn this form over and complete side two

MEDICATIONS	Allergies
List any medications you are currently taking, including eye drops: _____ _____ _____ _____ _____ Pharmacy Name _____	List any allergies you have to medications or other substances _____ _____ _____ _____ _____

Pregnant or Nursing? Yes No
 Alcohol use amount and frequency _____ Tobacco use amount and frequency _____

FAMILY MEDICAL HISTORY

Please note any immediate family member, (Father, Mother, Brother, Sister, Daughter, or Son) with any of the following conditions :
Disease/Condition: **Relationship to you**

Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Type 1 Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Type 2 Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Hyperthyroid	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Hypothyroid	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Cataract	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Macular degeneration	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

IN CASE OF EMERGENCY, CONTACT (specify someone who does not live in your household.)
 Name _____ Relationship _____ Phone # (____) _____

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and if applicable, Medigap benefits, be made either to me or on my behalf to St. Helens Eyecare Specialists for any services furnished to me by that provider. to the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers of Medicare and Medicaid services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Signature of Beneficiary, Guardian, or Personal Representative	Date
Please Print name of Beneficiary, Guardian, or Personal Representative	Date