Patient Information Sheet

Name (First, Middle, Last) _____ Preferred Name _____ Date ____/____/____
Address _____ Phone (work/home) _____/_____
City _____ State _____ Zip _____ Cell Phone _____
Guardian (if applicable) _____ Email _____
Birthdate ____/____/____ Last Eye Exam (date) _____ (doctor)_____ Marital Status _____
Occupation/Grade_____ Employer/School _____
Primary Vision Coverage _____ Insured Name _____ Insured D.O.B. ____/____/____
Relationship to Patient _____ Employer of Insured _____ ID#/Group _____
SSN of Insured _____ Secondary Vision Coverage _____ Name of Insured _____
Insured D.O.B. ____/____/____ Relationship to Patient _____ Employer of Insured _____

Race (please circle): American Indian or Alaskan Native Asian Black or African American Hispanic
Native Hawaiian or Other Pacific Islander White Prefer not to answer

Ethnicity (please circle): Hispanic or Latino Not Hispanic or Latino Prefer not to answer

Gender (please circle): Male Female Other

Medical History:

Name of primary care physician: _____ last visit: _____
List medications you take (include oral contraceptives, aspirin, over-the-counter medications, and supplements)

_____

_____

Are you currently pregnant and/or nursing? ____No ____Yes Are you colorblind? ____No ____Yes
Do you wear glasses? ____No ____Yes If yes, how old is your present pair? _____
Do you wear contacts? ____No ____Yes If yes, what brand? _____
Type of contacts: ____Rigid ____Soft ____Extended wear ____Daily ____1 Day ____Other
Are they comfortable? ____ No ____ Yes Solution Brand _____
Are you interested in Lasik? ____No ____Yes If so, and you wear contacts, how long have you worn them? _____

Family History

Please check any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

Disease/Condition	Relationship	Disease/Condition	Relationship
____Glaucoma	_____	____High Blood Pressure	_____
____Cataract	_____	____Diabetes	_____
____Macular Degeneration	_____	____Other	_____

Social History

– This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer. ___ Yes, I prefer to discuss my social history information directly with my doctor.
Do you drive? ___No ___Yes If yes, do you have visual difficulty when driving? ___No ___Yes If yes, please describe:

_____

Do you use tobacco products? ___No ___Yes If yes, type/amount/how long _____
Are you a: ___Former Smoker ___Current Occasional Smoker ___Current Every day Smoker
Do you drink alcohol? ___No ___Yes If yes, type/amount/how long _____
Do you use illegal drugs? ___No ___Yes If yes, type/amount/how long _____.
Are you a reader? ____No ____Yes Do you use the computer? _____No ____Yes
Do you play sports? ____No ____Yes, recreationally ____Yes, competitively

Review of Systems

Do you currently, or have you ever had, any problems in the following areas:

Allergic/Immunologic:	**YES**	**NO**
Drug allergy	_____	_____
Environmental allergy	_____	_____
Rheumatoid arthritis	_____	_____
HIV/AIDS	_____	_____
Lupus	_____	_____
Other:		
Eyes:		
Glaucoma	_____	_____
Cataract	_____	_____
Age-related macular degeneration	_____	_____
Surgery	_____	_____
If yes, type and date: _____		
Inflammatory disorders	_____	_____
Blurred vision	_____	_____
Double vision	_____	_____
Diabetes retinopathy	_____	_____
Carcinoma	_____	_____
Crossed or outturned eye	_____	_____
Dry/watery eye	_____	_____
Other:		
Musculoskeletal:		
Fibromyalgia	_____	_____
Muscular dystrophy	_____	_____
Osteoarthritis	_____	_____
Ankylosing spondylitis	_____	_____
Other:		
Cardiovascular:		
Heart disease	_____	_____
High blood pressure	_____	_____
Stroke	_____	_____
Vascular disease	_____	_____
Other:		
Gastrointestinal:		
Crohn's	_____	_____
Colitis	_____	_____
Ulcer	_____	_____
Digestive	_____	_____
Other:		
Neurological:		
Multiple sclerosis	_____	_____
Epilepsy	_____	_____
Seizures	_____	_____
Alzheimer's	_____	_____
Parkinson's	_____	_____
Cerebrovascular	_____	_____
Other:		

Constitutional:	**YES**	**NO**
Developmental disability	_____	_____
Weight loss	_____	_____
Fever	_____	_____
Fatigue	_____	_____
Trauma	_____	_____
Other:		
Genitourinary:		
STD, viral herpetic, chlamydia	_____	_____
Other:		
Psychiatric:		
Depression	_____	_____
Panic disorder/Anxiety	_____	_____
ADD/ADHD	_____	_____
Schizophrenia	_____	_____
Other:		
Ear, Nose, Mouth, and Throat:		
Upper resp. tract infection	_____	_____
Earache	_____	_____
Runny nose	_____	_____
Sore throat	_____	_____
Ringing/tinnitus	_____	_____
Other:		
Hematologic/Lymphatic:		
Anemia	_____	_____
Large volume blood loss	_____	_____
Leukemia	_____	_____
High cholesterol	_____	_____
Other:		
Respiratory:		
Asthma	_____	_____
Bronchitis	_____	_____
Emphysema	_____	_____
Sleep apnea	_____	_____
Other:		
Endocrine:		
Diabetes Type I	_____	_____
Diabetes Type II	_____	_____
Thyroid dysfunction	_____	_____
Hormonal dysfunction	_____	_____
Other:		
Integumentary:		
Eczema	_____	_____
Rosacea	_____	_____
Psoriasis	_____	_____
Other:		

If you checked yes for a drug allergy, please list below:

_____

If you have a condition not listed, please include below:

_____

_____

_____

If you have specialists you see, please name below:

Doctor's Signature _____ Date _____

PERMISSION TO SHARE PERSONAL HEALTH INFORMATION

Listed below are the names and phone numbers of individuals for whom I am giving permission to access information or materials from this office which pertain to me, my health status, my personal health record, and all other information contained within this office or its electronic database.

Name	Phone Number	Date Permitted	Date Removed

This release is valid unless revoked, in writing, and signed by you. However, such revocation will not affect disclosures made in regard to any previous authorization.

PERMISSION TO LEAVE TELEPHONE MESSAGES

_____ YES _____ NO

- Please initial **yes** or **no** to indicate whether we have permission to leave phone messages regarding your appointment times, requests for return calls, or the status of orders pertaining to this office.
- Do you have a preference as to how we contact you? (i.e. phone call, e-mail) Please indicate using the space below.

_____

PREFERRED PHARMACY

Name	Location	Phone

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY POLICY

- I have been informed of Sight to See's Notice of Privacy Practices and have been offered a copy.
- I realize that Sight to See is filing my insurance as a courtesy to me. In the event that my insurance does not pay as expected, I will be responsible for any balance due. I fully understand that insurance co-pays and all non-covered fees are due at the time of service. I hereby authorize Sight to See to release all information necessary to secure the payment of benefits. I request that payment of authorized insurance benefits be made either to me or on my behalf to my physician for any services furnished to me by that physician. I authorize the use of this signature on all insurance submissions.

_____ _____

Responsible party signature Date