PATIENT INFORMATION

Patient's Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Cell Phone# _____ Secondary # _____ Social Security Number _____

Date of Birth _____ Age _____ Sex M F _____ Marital Status M S W D

If Minor Parent's DOB _____ Parent's Employer _____

Parent's Name _____ Parent's SS# _____ Employer's Phone# _____

Referred By _____ Personal Physician _____

Patient's Employer _____ Business Address _____

Spouse's Name _____ Spouse's Employer _____

Email Address _____ Race _____

INSURANCE INFORMATION

Ins Company(Primary) _____ ID# _____

Insured Name (Other than self) _____ DOB _____ SS# _____

Ins Company(Secondary) _____ ID# _____

Insured Name (Other than self) _____ DOB _____ SS# _____

SIGNATURE AUTHORIZATION

I authorize release of medical information necessary to process my insurance claims. I authorize payment of benefits to the physician for services rendered. I understand I am financially responsible to the physician for any amount not covered by insurance. A copy of this authorization shall be considered as valid as the original.

Signature _____ Date _____

IN ORDER TO CONTROL OUR BILLING COSTS AND REDUCE FEE INCREASES, WE REQUEST THAT OFFICE VISITS BE PAID AT THE TIME OF SERVICE.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, do hereby acknowledge receipt of a copy of the Notice of Privacy Practices, Policies, and Procedures.

_____

Signature of Individual

_____

Date

In the event this request is made by the individual's personal representative: **(If Minor)**

_____

Signature of Personal Representative Date

_____

Legal Authority of Personal Representative

MEDICAL HISTORY

Date _____ Name _____ Age _____

YOUR HEALTH HISTORY

(Please check any of the following conditions you now have or have had in the past.)

- ❑ CANCER
- ❑ DIABETES
- ❑ HEART DISEASE
- ❑ HEART ATTACK
- ❑ RHEUMATIC FEVER
- ❑ HIGH BLOOD PRESSURE
- ❑ PALPITATIONS/FLUTTER
- ❑ PACEMAKER
- ❑ RESPIRATORY DISEASE
- ❑ CHRONIC COUGH
- ❑ HAY FEVER
- ❑ SHORTNESS OF BREATH
- ❑ ASTHMA
- ❑ EMPHYSEMA
- ❑ POSITIVE TB TEST
- ❑ SEIZURES/STROKES
- ❑ LOSS OF CONSCIOUSNESS
- ❑ BLEEDING TENDENCY
- ❑ DIGESTIVE DISEASE
- ❑ COLITIS
- ❑ STOMACH ULCERS
- ❑ HIATAL HERNIA/REFLUX
- ❑ LIVER DISEASE/HEPATITIS
- ❑ GLAUCOMA
- ❑ CATARACTS
- ❑ RETINAL DETACHMENT
- ❑ IRITIS
- ❑ CROSSED EYES
- ❑ LAZY EYE
- ❑ OTHER EYE DISEASE
- ❑ HIGH CHOLESTEROL
- ❑ MIGRAINE HEADACHE
- ❑ ARTHRITIS
- ❑ THYROID DISEASE
- ❑ SMOKE
- ❑ ALCOHOL USE
- ❑ HIV POSITIVE
- ❑ OTHER CONDITIONS (PLEASE LIST)

_____
_____
_____
_____
_____
_____

FAMILY HEALTH HISTORY

(Check all that apply)

- ❑ GLAUCOMA
- ❑ DIABETES
- ❑ HYPERTENSION
- ❑ HIGH CHOLESTEROL
- ❑ ARTHRITIS
- ❑ HEART DISEASE
- ❑ CATARACTS
- ❑ THYROID DISEASE

ANY OTHER DISEASES

_____
_____
_____
_____
_____
_____
_____
_____

MEDICATIONS (list medications, including aspirin, birth control pills, and all prescriptions)

Name	Dose	Frequency

PERSONAL PHYSICIANS _____

PREVIOUS SURGERY

EYE SURGERIES _____

OTHER SURGERIES _____

_____

_____

_____

ALLERGIES (Drug or other)

_____
_____
_____
_____
_____

Signature of person filling out form _____