PENNACHIO EYE

PATIENT INFORMATION SHEET

Patient's Name: _____ Date: _____

Home Phone: _____ Cell: _____ Other: _____

Mailing Address: _____
Street City State Zip

Date of Birth: _____/_____/_____ Age: _____ Social Security Number: _____-_____-_____

Marital Status: _____ Married _____ Single _____ Divorced _____ Widow(er)

Spouse's Name: _____

Primary Health Insurance: _____ (Please provide card)

Secondary Health Insurance: _____(Please provide card)

Name of Primary Insured, *if other than patient*: _____ DOB: _____/_____/_____

Employer: _____ Phone: _____

Family Physician: _____ Phone: _____

Name of Local Pharmacy: _____ Phone: _____

Mail Order Pharmacy: _____

How did you hear about us?

- ☐ Family or Friend referral (Name): _____
- ☐ Website / Internet Search
- ☐ Physician referral (Name): _____
- ☐ Other: _____

Preferred Method of Contact:

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Text Message ☐ Email

Email Address: _____@_____

EMERGENCY CONTACT:

Name: _____ Relationship: _____Phone: _____

Patient's Name: _____ MEDICAL INFORMATION

Do you have, or have you had any of the following: (check all that apply)

- ☐ Asthma
- ☐ Cataracts
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Macular Degeneration
- ☐ Other: _____

Do any of your relatives have any of the above diseases? If so, which disease(s), and what is their relationship to you?

_____

_____

Check any that apply:

☐ I am now, or it is possible that I am pregnant.

☐ I wear glasses or contact lenses. Date of last exam: _____ By: _____

☐ I use eye drops. Specify: _____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: (attach a separate sheet if necessary)

_____ _____

_____ _____

_____ _____

_____ _____

By your signature below, you authorize us to bill your insurance company (if applicable) on your behalf for any covered services and agree to the release of medical information about you to your insurance company as necessary to process your claim.

Your signature below also confirms your agreement to pay for any non-covered and/or out-of-pocket responsibilities such as co-pays and deductibles, at the time service is rendered.

PATIENT IS RESPONSIBLE TO VERIFY PROVIDER PARTICIPATION IN INSURANCE PLAN AND TO OBTAIN ANY REQUIRED INSURANCE AUTHORIZATIONS PRIOR TO VISIT.

Patient Signature: _____ Date: _____