PATIENT INFORMATION SHEET

Patient's Name: ______________________________________ Date: ______________________________

Home Phone: _______________________ Cell: ______________________ Other: _____________________

Mailing Address: ____
Street City State Zip

Date of Birth: _____/______/______ Sex: Male / Female Social Security Number: ______-_____-_______

Status: __ Married __ Single __ Divorced __ Widow(er) Spouse's Name: ____________________________

Race: ___American Indian or Alaska Native ___Asian ___Black or African American ___White
___Other Race ___Native Hawaiian or Other Pacific Islander ___Decline to Specify

Ethnicity: ___Hispanic or Latino ___Non-Hispanic or Latino ___Decline to Specify
(Information regarding race and ethnicity are for informational reporting only – you may decline to specify)

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: ____@_____________________________________

Patient's Name: MEDICAL INFORMATION

EMERGENCY CONTACT:

Name: ________________________ Relationship: ______________ Phone: ________________

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?

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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: ____

Medication Allergies (list any): ____

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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: ______________________