

PATIENT DEMOGRAPHIC & HEALTH HISTORY FORM

PATIENT'S NAME: Mr. Mrs. Miss Ms. Dr. Sex Male Female
Last _____ First _____
Marital Status M S W D Sep Cell (____) _____
Mailing Address _____
City _____ State _____ Zip Code _____ - _____
Birthdate _____ Age _____ CA DLic # _____
Email Address _____ @ _____
Social Sec. # _____ - _____ - _____ Home Phone (____) _____
Occupation _____ Employer _____
Address _____ Work Phone (____) _____
Spouse _____ Spouse Phone (____) _____

In case of emergency or appointment change, may we have the following information?

Name of nearest friend or relative not living with you _____
Relationship _____
Phone Day (____) _____ Phone Night (____) _____
Name of family (PCP) Doctor _____ City/State _____
Name of Optometrist _____ City/State _____
Referred by _____ May we send a thank you card? Yes No
 Physician Optometrist Friend Insurance Co. Internet Television Radio
 Newspaper Phone Book Other _____

PRIMARY INSURANCE COMPANY _____
Subscriber _____ ID # _____
Group # _____ Policy # _____

SECONDARY INSURANCE COMPANY _____
Subscriber _____ ID # _____
Group # _____ Policy # _____

ASSIGNMENT OF BENEFITS

I hereby irrevocably authorize _____ to make payments directly to Center for Sight of any insurance benefits otherwise payable to me, for professional services rendered to date, but not to exceed the stated charges for these services. I understand that I am responsible for any charges not paid by my insurance company, and for any charges not paid within sixty (60) days of billing to said insurance company. A copy of this authorization shall be valid as the original.

Release of Information: I hereby authorize Center for Sight to furnish and disclose all known facts concerning my care to my insurance company and to other physicians upon my request. A copy of this authorization shall be as valid as the original.

Patient Signature _____ Date _____

HEALTH QUESTIONNAIRE

Please list any eye drops you are currently taking. (Please note dosage) _____

Are you allergic to any medications? If yes, what medications, and what effects do they have on you?

Are you allergic to adhesive tape? Yes No Are you allergic to iodine? Yes No

Do you drive a vehicle? Yes No Do you use recreational drugs? Yes No

Do you smoke? Yes No If yes, how many cigarettes per day? _____

Do you drink alcohol? Yes No If yes, how often? Daily Weekly Monthly

Have you ever had any major surgery or illness? Yes No

If yes, please list and note date of any surgery/surgeries

Date _____ Surgery Type _____

Date _____ Surgery Type _____

Date _____ Surgery Type _____

Date _____ Surgery Type _____

Have you ever had a blood transfusion? Yes No

Check any of the following illnesses and/or surgeries you have had

- | | |
|---|--|
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Epilepsy (seizures) | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Abnormal Shortness of Breath | <input type="checkbox"/> Nerve Paralysis |
| <input type="checkbox"/> Asthma or Wheezing | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Back Pain / Problems | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> Easy Bruising or Bleeding | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> _____ |

List all medication(s) you are taking showing medicine name/frequency and dose

Patient Signature (or legal Guardian) _____ Date _____