Today's Date _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Gender: Male/Female SSN: ____-____-_____ Date of Birth: ____/____/____ Age: _____

Mailing Address _____ City/State_____ Zip _____

Home # _____ Cell # _____ Work # _____

Email: _____

Employer: _____ Occupation: _____

Marital Status: S/M/D/W Spouse's Name _____

Emergency Contact:_____ Phone # _____ Relationship: _____

INSURANCE INFORMATION

Vision Insurance: _____ Medical Insurance: _____

Subscriber's Name: _____Relationship to Patient: _____

Subscriber's SSN:____-____-_____ Date of Birth: ____/____/____ Employer: _____

ASSIGNMENT OF BENEFITS

I understand that my signature requests that payments from my insurance be made directly to the above named facility. I further authorize the release of any necessary information, including medical information, for the payment of this or any related claim.

Patient's Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for your services, and to conduct healthcare operations involving our office. The Notice of Privacy Practices you have been given describes these uses and disclosures in detail.

I acknowledge that I have received the Notice of Privacy Practices from Pauls Valley Eye Clinic.

Patient's Signature: _____ Date: _____

(Over)

MEDICAL INFORMATION

Date of Last Medical Exam: _____ Name of Medical Doctor: _____

Name of Pharmacy: _____

List any medications you take (including oral contraceptives, aspirin and over the counter meds): _____

_____

_____

Do you have any allergies? If yes, explain: _____

Do you have any allergies to medication? If yes, explain: _____

List all major injuries, surgeries and/or hospitalization you have had: _____

_____ Are you nursing and/or pregnant? Yes / No

Review of Symptoms and Family History

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

Gastrointestinal	Yes / No / Self / Relative	Diabetes	Yes / No / Self / Relative
Ears/Nose/Throat	Yes / No / Self / Relative	Musculoskeletal	Yes / No / Self / Relative
Cardiovascular	Yes / No / Self / Relative	Integumentary (skin)	Yes / No / Self / Relative
Respiratory	Yes / No / Self / Relative	Mental	Yes / No / Self / Relative
Eyes	Yes / No / Self / Relative	Endocrine (glands)	Yes / No / Self / Relative
Neurological	Yes / No / Self / Relative	Blood / Lymph	Yes / No / Self / Relative
Genitourinary	Yes / No / Self / Relative	Allergies / Immunologic	Yes / No / Self / Relative
High Blood Pressure	Yes / No / Self / Relative	Other	Yes / No / Self / Relative

Please note any family history (parents, grandparents, siblings, children; living or deceased)
(If you mark yes, please specify which family member)

Blindness	Yes / No _____	Diabetes	Yes / No _____
Cataracts	Yes / No _____	Heart Disease	Yes / No _____
Crossed Eyes	Yes / No _____	High Blood Pressure	Yes / No _____
Macular Degeneration	Yes / No _____	Kidney Disease	Yes / No _____
Retinal Detachment	Yes / No _____	Lupus	Yes / No _____
Arthritis	Yes / No _____	Thyroid Disease	Yes / No _____
Cancer	Yes / No _____	Other	Yes / No _____

Social History

Do you use tobacco products? Yes / No Alcohol? Yes / No Other Substances? Yes / No

Have you ever been exposed to or infected with: **HIV** Yes / No **Hepatitis** Yes / No **Gonorrhea** Yes / No

Syphilis Yes / No If yes, Please explain: _____

PERSONAL EYE INFORMATION

Eye Operations? _____ Type _____ Date _____

Eye Injury? _____ Kind _____ Date _____

Glaucoma? _____ Cataracts? _____ Dry Eyes? _____ Blurred Vision? _____

Other Eye Problems? _____ Describe _____

Do You Wear Glasses? _____ Contact Lenses? _____

Patient's Signature _____