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: _____ Race: _____

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)

Personal Medical History

Name of Medical Doctor: _____ Location of Medical Doctor: _____

Please List or Circle General Health Condition(s): _____

_____

Diabetes / Hypertension / Stroke / Cancer / Lupus / Heart Disease / Kidney Disease / Thyroid Disease

Please List or Circle Eye Health Condition(s): _____

Glaucoma / Cataracts / Macular Degeneration / Color Blindness / Retinal Detachment / Blindness

Please List All General Health Surgeries: _____

Please List or Circle All Eye Surgeries: _____

Cataract Surgery / Lasik Surgery Right Eye - Date:_____ Left Eye - Date:_____

Current Medication(s) — (prescription or over-the-counter) If you have a med list with you, please provide so we may make a copy.

_____

Current Eye Medication(s) - (prescription or over-the-counter)

Name(s): _____ How often? _____

Drug Allergies? Yes / No If so, please list: _____

Family Medical History

Please List or Circle All That Apply: _____

Diabetes / Hypertension / Stroke / Cancer / Lupus / Heart Disease / Kidney Disease / Thyroid Disease

Glaucoma / Cataracts / Macular Degeneration / Color Blindness / Retinal Detachment / Blindness

Social History

Smoke? Yes / No Alcohol? Yes / No Other Substances? Yes / No Aids/HIV Yes / No

Review of Systems

Allergy	Yes / No	Hematologic/Lymphatic	Yes / No
Cardiovascular	Yes / No	Immunologic	Yes / No
Constitutional	Yes / No	Integumentary (skin)	Yes / No
Endocrine	Yes / No	Musculoskeletal	Yes / No
Gastrointestinal	Yes / No	Neurological	Yes / No
Genitourinary	Yes / No	Psychiatric	Yes / No
Ears, Nose, Mouth, Throat	Yes / No	Respiratory	Yes / No

Patient's Signature:

_____