PATIENT DEMOGRAPHIC

Today's Date: _____ / ______ / ________ Name: ____ Sex: M F

What name should we use to address you? __________________________ Birth Date _____ / _____ / ______ Age: ________

Ethnicity __ Hispanic or Latino __Native Hawaiian / Other Pacific Island __Not Hispanic or Latino Race __American Indian __Asian __Black / AfricanAmerican __Hispanic __Hawaiian / Other Pacific Island __White Marital Status __Single __Never Married __Married __Divorced

Preferred Language __English __Spanish __ French __Japanese Communication Preference __Phone __E-mail __Text __Mail

Address: ____ City: ________________________ State: ______

Zip Code: ______________ Home ph#: ______________________ Work ph# ____________________ Cell ph# ________________

SSN: ________________________ Driver's Lic # ____________________________ State: ______ Expiration _________________

E-mail address: ____ Employer: _____________________________________

Occupation: ____________________________ Emergency Contact: ______________________________ Ph#: ___________________

REGARDING INSURANCE

Our office is pleased to assist you in filling claims with your insurance company for the reimbursement of these expenses. *The patient is responsible for knowing what your insurance does or does not cover.*

**The patient is responsible to pay any deductible and co-payments at the time services are rendered.*
**Any portion of the billed amount that is not covered by your insurance will become the patient's responsibility.*
**Our office NEVER guarantees that your insurance will pay for services rendered.*
**Not all services are covered by your insurance.*

Insurance Company: ____ Primary Insured Name: ________________________________

Policy Holder's DOB: _____ / _____ / ________ ID / SSN: _______________________________ Group#: ______________________

Insurance ph#: _________________________

MEDICAL HISTORY

Emergency Contact: ____ Ph#: ____________________________________

Name of Primary Physician: ____ Dr's Ph#: _________________________________

Do you have allergies to medications? If so, please list: ____

List any medications you take including oral contraceptives, aspirin, and/or over-the-counter medications: _____________________
____
____

Are you pregnant or nursing? Y N Do you become weak or faint with dental work, shots or giving blood? Y N

Any family history of the following?

Condition			
Diabetes	Y	N	If so, what relation? ________________________
Heart disease	Y	N	If so, what relation? ________________________
High blood pressure	Y	N	If so, what relation? ________________________
High cholesterol	Y	N	If so, what relation? ________________________
Kidney disease	Y	N	If so, what relation? ________________________
Lupus	Y	N	If so, what relation? ________________________
Thyroid disease	Y	N	If so, what relation? ________________________

please see reverse side for continuation of medical history

SOCIAL HISTORY *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

___ *Yes, I would prefer to discuss my social history information with my doctor.*

Do you use tobacco products? Y N If yes, type/ amount/ how long? ____________________

Do you drink alcohol? Y N If yes, type/ amount/ how long? ____________________

Do you use illegal drugs? Y N If yes, type/ amount/ how long? ____________________

Have you ever been diagnosed and / or treated for: ___ Gonorrhea ___ Hepatitis ___ HIV ___ Syphilis ___ Herpes I / II

REVIEW OF SYSTEMS

EYES			INTEGUMENTARY (skin)			CARDIOVASCULAR		
Loss of vision	Y	N	Adult acne (Rosacea)	Y	N	Heart pain	Y	N
Blurred vision	Y	N	NEUROLOGICAL			High blood pressure	Y	N
Distorted vision / halos	Y	N	Headaches	Y	N	Vascular disease	Y	N
Double vision	Y	N	Migraines	Y	N	GASTROINTESTINAL		
Dryness	Y	N	Seizures	Y	N	Diarrhea	Y	N
Mucous discharge	Y	N	ENDOCRINE			Constipation	Y	N
Redness	Y	N	Thyroid / other glands	Y	N	Gastric bypass / reflux	Y	N
Sandy of gritty feeling	Y	N	Diabetes	Y	N	GENITOURINARY		
Itching	Y	N	PSYCHIATRIC			Genitals / kidney / bladder	Y	N
Burning	Y	N	Anxiety	Y	N	BONES, JOINTS, MUSCLES		
Foreign body sensation	y	N	Depression	Y	N	Rheumatoid arthritis	Y	N
Excess tearing / watering	Y	N	EARS, NOSE MOUTH, THROAT			Muscle pain	Y	N
Glare / light sensitivity	Y	N	Allergies / hay fever	Y	N	Joint pain	Y	N
Eye pain	Y	N	Sinus congestion	Y	N	LYMPHATIC / HEMATOLOGIC		
Flashes or floaters	Y	N	Chronic cough	Y	N	Anemia	Y	N
Tired Eyes	Y	N	Dry mouth / throat	Y	N	Blood clotting disorder	Y	N
CONSTITUTIONAL			RESPIRATORY			ALLERGIES / IMMUNOLOGIC		
Fever	Y	N	Asthma	Y	N	Environmental	Y	N
Weight loss / gain	Y	N	Chronic bronchitis	Y	N	Medical	Y	N
			Emphysema	Y	N			

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

____

____

____

OCULAR HISTORY When was your last eye examination? ____________________ Where? ____________________

Do you wear glasses? Y N If yes, how old is your latest pair? ____________________

Have you had any eye surgeries? Y N If yes, please list: ____________________

Do you wear contact lenses? Y N If yes, please state brand: ____________________

Type of contact lenses: Rigid Soft Toric Bifocal Other

Replacement schedule: Daily disposable Two week One month Other ____________________

Wear schedule: Daily only Occasional over-night Extended wear

Any family history of blindness, glaucoma, macular degeneration, or retinal detachments? If so, please detail:

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Patient signature: ____________________ ***Date*:** ____________________