

**PATIENT INFORMATION**

Name \_\_\_\_\_ Address \_\_\_\_\_  
LAST FIRST MI

City/State/Zip \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Email \_\_\_\_\_

Are you:  Minor  Married  Divorced  Widowed  Separated  Single

Your employer \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Reason for today's visit? \_\_\_\_\_ Referred By? \_\_\_\_\_

Contact/Guardian \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**INSURANCE INFORMATION** *(please provide us a copy of your cards)*

Insurance Company \_\_\_\_\_ ID# \_\_\_\_\_

**ANY SECONDARY INSURANCE?**

Insurance Company \_\_\_\_\_ ID# \_\_\_\_\_

**AUTHORIZATION**

I authorize Eye Specialists of Carolina, PA to release any medical information necessary to process an insurance claim for payment on my behalf. Furthermore, if I am not eligible for insurance, I understand that I am personally responsible for full payment to Eye Specialists of Carolina, PA for all medical services rendered.

Signature (patient or parent) \_\_\_\_\_ Date \_\_\_\_\_

# MEDICAL AND EYE HISTORY

Last Eye Exam? \_\_\_\_\_ By Whom? \_\_\_\_\_

Medical/Primary Physician \_\_\_\_\_

Other Physicians you see regularly? \_\_\_\_\_

**ALLERGIES (to medications, latex, x-ray dyes, etc)**

None

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Present/Previous Eye Problems**

	Patient	Family
Cataract	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>
Strabismus	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Problems	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>
Iritis	<input type="checkbox"/>	<input type="checkbox"/>

**CURRENT MEDICATIONS**

None

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Present/Previous Medical Problems**

	Patient	Family
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Breathing Problems	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
Depression/Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
HIV/AIDs	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis/Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Problems	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Other Health Problems	_____	

**PAST SURGERIES**

None

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you smoke?      Yes     No

How much/often? \_\_\_\_\_

Do you drink alcohol?    Yes     No

How much/often? \_\_\_\_\_

Office use:

**REVIEW DATES**

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____