WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your health.

PATIENT INFORMATION – PLEASE PRINT CLEARLY Date_____

Name_____ Social Security #_____
Last First

Address_____ Email:_____ Cell:_____

City_____ State_____ Zip_____ **Home** Phone_____

Sex __M __F Age_____ Birth Date_____ Single__ Married__ Widowed___ Separated___ Divorced___

Patient Employed by_____ Occupation_____

Business Address_____ Business Phone_____

Whom may we thank for referring you? _____

Notify in case of emergency_____HomePhone_____WorkPhone_____

Name of Primary Care Physician_____Telephone No._____

PRIMARY INSURANCE

Insurance Subscriber_____
Last Name First Name Middle Initial

Relationship to Patient:_____Social Security #_____Date of Birth_____

Address (if different from patient)_____Telephone_____

City_____State_____Zip_____

Subscriber Employed by:_____Occupation:_____

Insurance Company:_____Phone:_____

Contract #:_____Group #:_____Subscriber #:_____

MEDICAL INFORMATION

Is your general health EXCELLENT GOOD FAIR POOR

Do you have problems with any of these systems? (please circle all that apply)

Eyes	Y / N				
Gastrointestinal	Y / N	Nervous	Y / N	Mental	Y / N
Ears / Nose / Throat	Y / N	Genitourinary	Y / N	Endocrine (glands)	Y / N
Cardiovascular	Y / N	Musculoskeletal	Y / N	Blood / Lymph	Y / N
Respiratory	Y / N	Skin	Y / N	Allergic / Immunologic	Y / N

Please Explain:_____

MEDICAL INFORMATION – CONTINUED

Please answer all questions:

Diabetes Y / N Type_____ Date of Diagnosis_____

Seasonal/ Food/ pet Allergies Y / N Allergic to what_____ What Happens?_____

Allergy to Medications? Y/ N Describe_____ Headaches? Y / N

Other Health Problems_____

Current medication(s):_____

Have you had any operations? Y / N What kind?_____When?_____

Do you use cigarettes / tobacco?_____ Alcohol?_____ Other substances? _____

Date of last general physical:_____Date of last tetanus shot _____

FAMILY HISTORY

High Blood Pressure	Y / N	Relation_____	Macular Degeneration	Y / N	Relation _____
Diabetes	Y / N	Relation _____	Retinal Detachment	Y / N	Relation _____
Glaucoma	Y / N	Relation _____	Cataracts	Y / N	Relation _____
Other Eye Condition(s)	Y / N	What kind _____			Relation _____

PERSONAL EYE INFORMATION

Have you had any eye operations? Y / N Type _____ Date _____

Have you had an eye injury? Y / N Type _____ Date _____

Do you have glaucoma? Y / N Cataracts? Y / N Dry Eyes? Y / N Blurred Vision Y / N

Other eye problems? Y / N What kind? _____

Do you wear glasses? Y / N Contact Lenses? Y / N Type: _____

Additonal information _____

COMPUTER (VDT) QUESTIONNAIRE

Time spent at Computer : _____Hours per day Work is performed while: Sitting _____ Other _____

Lighting in work area (please describe: _____

Are you experiencing any of the following symptoms while at your VDT?

Check where appropriate:

___Headaches ___Sore or Tired Eyes (Strain)

___Blurred Near Vision ___Glare (Light) Sensitivity ___Blurred Distance Vision
___Dry or Watery Eyes ___Burning, Itching, or Red Eye ___Double Vision
___Slowness in Focusing (Distant to Near and Back ___Neck and Shoulder, or Back Pain

Do you wear glasses while working at the VDT? Y / N
Do you wear contact lenses while working at the VDT? Y / N
Do you view reference materials while working at the VDT? Y / N If yes, what percentage of the time? _____

Distance from eye to VDT screen: _____inches From eye to keyboard _____ inches From eye to reference material _____inches
Center of VDT screen is Above / Below / Equal to eye level. Reference material is Above / Below / Equal to eye level.

Assignment and Release

I authorize payment of benefits directly to Downtown Eye Associates for services rendered. I also authorize release of any medical information that may be required in determination of such benefits.

I understand that some services may require approval of my primary care physician for coverage and that, if I do not obtain approval, I am financially liable for the services.

I understand that some services and products may not be covered by my insurance carrier and benefit information does not constitute approval of payment. Fees not paid by my insurance carrier will be my responsibility.

Signature_____