

WELCOME TO OUR OFFICE

_____ Loaded By

_____ Labels Print

Name _____ Nick Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Office _____ Mobile _____ email _____

Age _____ Birthday _____ SS# _____ Physician _____ Referral Needed Y

Occupation _____ Employer _____

Same as above

Responsible party if not patient _____ Relation to patient _____

Address _____ SS# _____

City _____ State _____ Zip _____

Home Phone _____ Office _____ Mobile _____ Email _____

Employer _____

PLEASE CIRCLE METHOD OF PAYMENT: CASH CHECK MASTERCARD VISA

I understand that I am fully responsible for this account, and will pay any fees involved in the collection of this account. In the event that Insurance claims are filed for me, I authorize payment directly to my doctor unless prior arrangements have been made.

Signature: _____ Date: _____

Name _____ Date _____

May we thank someone for referring you to our office? _____

Who has your previous eye record? _____

Please list family members who are patients: _____

Primary care physician: _____

Address: _____

Are you interested in contacts? Y N

REVIEW OF SYSTEMS

Do you currently have problems in the following areas:

CONSTITUTIONAL			EARS, NOSE, MOUTH, THROAT		
Fever, Weight Loss/Gain	Y	N ?	Allergies/Hay Fever	Y	N ?
INTEGUMENTARY (Skin)	Y	N ?	Dry Throat/Mouth	Y	N ?
NEUROLOGICAL			RESPIRATORY		
Headache/Seizures	Y	N ?	Asthma/Breathing	Y	N ?
ENDOCRINE			VASCULAR/CARDIOVASCULAR		
Thyroid/Other Glands	Y	N ?	Diabetes	Y	N ?
GASTROINTESTINAL (Stomach)	Y	N ?	High Blood Pressure	Y	N ?
GENITOURINARY	Y	N ?	High Cholesterol	Y	N ?
LYMPHATIC/HEMATOLOGIC	Y	N ?	BONES/JOINTS/MUSCLES		
Anemia/Bleeding	Y	N ?	Arthritis	Y	N ?
PSYCHIATRIC	Y	N ?	IMMUNOLOGIC	Y	N ?
Depression	Y	N ?			

Other health conditions not listed above: _____

SOCIAL HISTORY

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

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 exposed to [] Gonorrhea [] Hepatitis [] HIV [] Syphilis [] never exposed

PLEASE READ CAREFULLY: I understand that I am responsible for this account, and will pay fees involved in the collection of this account. In the event that insurance claims are filled for me, I authorize payment directly to my doctor unless prior arrangement has been made.

PLEASE CIRCLE METHOD OF PAYMENT FOR TODAY'S VISIT:

CASH CHECK MASTERCARD/VISA

MEDICARE VSP SOUTHERN HEALTH (MEDICAL) CIGNA PPO ANTHEM (EXPAND BENEFITS)

Initial						
Date						

Reviewed by