## **PATIENT INFORMATION**

NAME:			DOB/	/ SS#	
FIRST	MI LAST				
ADDRESS:		CITY		STATE	ZIP
PHONE # ()	AGE	M / F	M S W D	DRIVERS LIC#	
CELL # ()	E-MAIL AD	DRESS:			
REFERRED BY:		PRIMAR	Y DOCTOR:		
MOST RECENT EYE DOCT	OR:			ST SEEN:	
		PLOYMENT INF RENT IF PATIENT			
EMPLOYER:			WORK F	PHONE #	
SPOUSE NAME:	EMPLO	YER:	WORK	PHONE #	
	RE	SPONSIBL	E PARTY		
NAME					
		_ADDNE33			<del></del>
PHONE # ()		ANCE INE	ORMATION		
		_	our insurance card		
DDIMADV INICI IDANICE					
PRIIVIARY INSURANCE		_ SECONDARI	TINSUKANCE		
SUBSCRIBER NAME:		SUBSCRIBER	R NAME:		
SUBSCRIBER DOB:	/ /	SUBSCRIBER DITIONAL INFO		/	
	ADI	DITIONAL INFO	SKIVIATION		
FRIEND / RELATIVE (NOT RELATIONSHIP TO PATIE	LIVING WITH YOU) NT			PHONE # ()	
		AUTHORIZA <sup>-</sup>	TIONS		
<b>As a courtesy,</b> yo	our insurance companies will	be billed. How	ever, co-payments	and payments towards o	deductible are du
at time of services rende	red. I understand I am respo ze the physicians of Gregory	nsible for any a	mounts not covere	ed by insurance. All credi	t cards accepted.
-	cal Associates to perform an				
	formation to insurance carrie		-	tments. I authorize the re	elease of records
	reimbursement of benefits to the physician all payments	-		entical convices randored	to musalf or mu
	est payment of government b				to mysen or my
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SIGNATURE OF RESPONS	IRI F PARTV				
SIGNATIONE OF IVESTORS	IDELIANII				

List any medications you to	ake (i	includin	g oral co	ntracept	tives, aspirin, o	ver the	counter r	medicatio	ns and	l home r	emedie	s):
List all major injuries, surg	eries	, and/or	hospita	lizations	you have had:							
List any of the following th										aucoma	, retinal	disease
cataracts, eye infections of	r eye	injury: _										
Are you pregnant and/or n	nursir	ng?	□ no	□ yes								
FAMILY HISTORY												
Please note any family hist	tory (				siblings, childre	n; living	or decea	ised) for t				is:
		NO	YES	?					NO	YES	?	
Blindness					Diabetes							
Cataract					Heart Disease							
Crossed Eyes					High Blood Pr							
Glaucoma					Kidney Diseas	e						
					Lupus Thursid Disse							
Retinal Detachment/Disea Cancer	ase				Thyroid Disea							
Cancer					Other							
Social History This informa	tion is	kept stric	tly confide	ential. How	vever. vou mav dis	cuss this r	oortion dire	ectly with th	ne docto	r if vou pro	efer.	
•					ocial History inforr						<i>-,</i>	
Do you use tobacco produ												_
					ii yes, type/ai							
Do you drink alcohol?		□ no	□ yes		If yes, type/ar	mount/h	ow long:					_
Do you drink alcohol?		□ no	□ yes		If yes, type/ar	mount/h	ow long:					
Do you drink alcohol? Do you use illegal drugs?		□ no □ no	□ yes		If yes, type/ar If yes, type/ar	mount/h mount/h	ow long: ow long:	:				-
	ed to	□ no □ no	□ yes		If yes, type/ar If yes, type/ar	mount/h mount/h	ow long: ow long:	:				-
Do you drink alcohol? Do you use illegal drugs? Have you ever been expos REVIEW OF SYSTEN	ed to <b>//S:</b>	□ no □ no o or infe	□ yes □ yes cted with	h:	If yes, type/aı If yes, type/aı □ Gonorrhea	nount/h nount/h □ Her	ow long: ow long:	:				-
Do you drink alcohol? Do you use illegal drugs? Have you ever been expos	ed to <b>1S:</b> you e	□ no □ no o or infe	uyes uyes eted with any pro	h:	If yes, type/ai If yes, type/ai Gonorrhea the following	nount/h nount/h □ Her	ow long: ow long:	:	□ Syp	hilis	NO	YES
Do you drink alcohol? Do you use illegal drugs? Have you ever been expos REVIEW OF SYSTEN Do you currently, or have you	ed to <b>1S:</b> you e	no no or infectiver had	uyes uyes eted with any pro	h: oblems in	If yes, type/ai If yes, type/ai Gonorrhea the following	mount/h mount/h □ Hep areas:	now long: now long: patitis	: HIV	□ Syp	hilis		-
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