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 ADDRESS: _____

REFERRED BY: _____ PRIMARY DOCTOR: _____

MOST RECENT EYE DOCTOR: _____ DATE LAST SEEN: _____

EMPLOYMENT INFORMATION
(PARENT IF PATIENT IS A MINOR)

EMPLOYER: _____ WORK PHONE # _____

SPOUSE NAME: _____ EMPLOYER: _____ WORK PHONE # _____

RESPONSIBLE PARTY

NAME _____ ADDRESS _____

PHONE # (____)_____ _____

INSURANCE INFORMATION

Please provide a copy of your insurance card

PRIMARY INSURANCE _____ SECONDARY INSURANCE _____

SUBSCRIBER NAME: _____ SUBSCRIBER NAME: _____

SUBSCRIBER DOB: _____/_____/_____ SUBSCRIBER DOB: _____/_____/_____

ADDITIONAL INFORMATION

FRIEND / RELATIVE (NOT LIVING WITH YOU)_____ PHONE # (_____) _____
RELATIONSHIP TO PATIENT _____

AUTHORIZATIONS

As a courtesy, your insurance companies will be billed. However, co-payments and payments towards deductible are due at time of services rendered. I understand I am responsible for any amounts not covered by insurance. All credit cards accepted.

I hereby authorize the physicians of Gregory A. Stainer, M.D., F.A.C.S., A Professional Medical Corporation / Southwest Eye Care and Laser Medical Associates to perform any and all forms of treatment, medications and therapy, and bill my insurance, and furnish information to insurance carriers concerning my illness and treatments. I authorize the release of records necessary to assist in the reimbursement of benefits from my insurance company.

I hereby assign to the physician all payments from insurance for medical and optical services rendered to myself or my dependents. I also request payment of government benefits to the party who accepts assignment.

_____ _____/_____/_____
SIGNATURE OF RESPONSIBLE PARTY

PLEASE TURN THIS FORM OVER AND COMPLETE SIDE TWO

MEDICAL HISTORY

Do you have any allergies to medication? □ no □ yes If yes, explain: _____

_____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

_____

_____

List all major injuries, surgeries, and/or hospitalizations you have had: _____

_____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: _____

Are you pregnant and/or nursing? □ no □ yes

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

	NO	YES	?		NO	YES	?
Blindness	□	□	□	Diabetes	□	□	□
Cataract	□	□	□	Heart Disease	□	□	□
Crossed Eyes	□	□	□	High Blood Pressure	□	□	□
Glaucoma	□	□	□	Kidney Disease	□	□	□
Macular Degeneration	□	□	□	Lupus	□	□	□
Retinal Detachment/Disease	□	□	□	Thyroid Disease	□	□	□
Cancer	□	□	□	Other _____	□	□	□

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 directly with my doctor. (check box)

Do you use tobacco products □ no □ yes If yes, type/amount/how long: _____

Do you drink alcohol? □ no □ yes If yes, type/amount/how long: _____

Do you use illegal drugs? □ no □ yes If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: □ Gonorrhea □ Hepatitis □ HIV □ Syphilis

REVIEW OF SYSTEMS:

Do you currently, or have you ever had any problems in the following areas:

EYES:	**NO**	**YES**	**CONSTITUTIONAL**	**NO**	**YES**	**RESPIRATORY**	**NO**	**YES**
Loss of Vision	□	□	Fever	□	□	Asthma	□	□
Blurred Vision	□	□	Weight Loss/Gain	□	□	Chronic Bronchitis	□	□
Distorted Vision/Halo	□	□	**INTEGUMENTARY(Skin)**	□	□	Emphysema	□	□
Loss of Side Vision	□	□	**NEUROLOGICAL**			**VASCULAR/CARDIOVASCULAR**		
Double Vision	□	□	Headaches	□	□	Diabetes	□	□
Dryness	□	□	Migraines	□	□	Heart Pain	□	□
Mucous Discharge	□	□	Seizures	□	□	High blood pressure	□	□
Redness	□	□	**EARS, NOSE, MOUTH, THROAT**			Vascular Disease	□	□
Sandy or Gritty Feeling	□	□	Allergies/Hay Fever	□	□	**GASTROINTESTINAL**		
Itching	□	□	Sinus Congestion	□	□	Diarrhea	□	□
Burning	□	□	Running Nose	□	□	Constipation	□	□
Foreign Body Sensation	□	□	Post-Nasal Drip	□	□	**GENITOURINARY**		
Tearing/Watering	□	□	Chronic Cough	□	□	Genitals/Kidney/Bladder	□	□
Glare/Light Sensitivity	□	□	Dry Throat/Mouth	□	□	**BONES/JOINTS/MUSCLES**		
Eye Pain or Soreness	□	□	**ENDOCRINE**			Rheumatoid Arthritis	□	□
Chronic Infection of			Thyroid/Other Glands	□	□	Muscle Pain	□	□
Eye or Lid	□	□	**ALLERGIC/IMMUNOLOGIC**	□	□	Joint Pain	□	□
Sties or Chalazion	□	□				**LYMPHATIC/HEMATOLOGIC**		
Flashers/Floaters in Vision	□	□	**PSYCHIATRIC**	□	□	Anemia	□	□
						Bleeding Problems	□	□

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

_____

_____