Thank you for taking the time to complete this form, Dr. DeForrest

PATIENT INFORMATION Today's Date: ____/____/____

Last Name: _____ First Name: _____ Middle Initial: _____

Title: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Master ☐ Miss Gender: ☐ M ☐ F

SS#: ____ -- _____ -- _____ Birth Date: ____/____/____ Age _____

Marital Status: ☐ S ☐ M If married, spouse's name: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Your preferred contact method: ☐ Home phone ☐ Work Phone ☐ Cell phone ☐ Email

Occupation: _____ Employer: _____

How were you referred to our office? _____

PRIMARY CARDHOLDER INSURANCE INFORMATION

Primary Insurance Holder: _____ Birth Date: ____/____/____

Name of Vision Insurance: _____ Primary's SS#: _____--_____--_____

Name of Medical Insurance: _____

Employer: _____ Relationship to patient: _____

HEALTH HISTORY

Primary Care Physician: _____ Last Medical Exam ____/____/____

Please list any allergies to medications: _____

_____

Please list any medications you are currently taking: _____

_____

List all MAJOR injuries, surgeries, and/or hospital visits you have had: (include the year of occurrence)

_____

Have you had any *surgeries* or *injuries* to your **EYES**? If so, please list: _____

_____

Are you pregnant and/or nursing? ☐ Yes ☐ No

Do you wear glasses? ☐ Yes ☐ No If yes, how old is your current pair of glasses? _____

Do you wear contact lenses? ☐ Yes ☐ No If yes, how old is your current pair of contacts? _____

Type of contact lenses: _____ Are they comfortable? ☐ Yes ☐ No

What is your reason for today's visit? _____

When was your last eye exam? ____/____/____

RACE

☐White ☐Hispanic ☐Black or African American ☐Asian ☐American Indian/Alaskan ☐Native Hawaiian/Pacific Island ☐Other_____

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

☐ *I wish to discuss my social history directly with the doctor*

Do you drive? ☐ Yes ☐ No If yes, do you have difficulty seeing when driving? ☐ Yes ☐ No

If yes, please explain: _____

Do you use tobacco products? ☐ Yes ☐ No If yes, type/amount/how long _____

Do you drink alcohol? ☐ Yes ☐ No If yes, amount/how long _____

Do you use illegal drugs? ☐ Yes ☐ No If yes, amount/type/how long _____

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

FAMILY HISTORY *Please note any family history for the following conditions* ***(Specify mother's or father's side)***

DISEASE/CONDITION		RELATIONSHIP	DISEASE/CONDITION		RELATIONSHIP
Blindness	☐ Yes ☐ No	_____	Macular Degeneration	☐ Yes ☐ No	_____
Crossed Eyes	☐ Yes ☐ No	_____	Diabetes	☐ Yes ☐ No	_____
Glaucoma	☐ Yes ☐ No	_____	High Blood Pressure	☐ Yes ☐ No	_____

PERSONAL MEDICAL HISTORY

Do you suffer from and/or have you received treatment for any of the following:
(Please check all that apply and put the **YEAR** you were diagnosed)

ALLERGIC/IMMUNOLOGIC

☐ Allergies _____
☐ Lupus _____
☐ Fibromyalgia _____
☐ Multiple Sclerosis _____

BONES/JOINTS/MUSCLES

☐ Rheumatoid Arthritis _____
☐ Muscle Pain _____
☐ Joint Pain _____

CANCER

Type_____Year _____
Type_____Year _____
Type_____Year _____

CONSTITUTIONAL

☐ Fever, Weight Loss/Gain _____

EARS, NOSE, MOUTH, THROAT

☐ Allergies/Hay Fever _____
☐ Sinus Congestion _____

ENDOCRINE

☐ Diabetes _____
☐ Thyroid/Other Glands _____

EYES

☐ Blindness _____
☐ Cataract _____
☐ Crossed Eyes _____
☐ Glaucoma _____
☐ Macular Degeneration _____
☐ Retinal Detachment _____
☐ Loss of Vision/Side Vision_____
☐ Blurred Vision _____
☐ Tired Eyes _____
☐ Distorted Vision/Halos _____
☐ Double Vision _____
☐ Dryness _____
☐ Redness _____
☐ Sandy/Gritty Feeling _____
☐ Itching/Burning _____
☐ Excess Tearing/Watering _____
☐ Lazy Eye _____
☐ Retinal Disease _____
☐ Eye Infections _____
☐ Eye Injury _____
☐ Glare/Light Sensitivity _____
☐ Eye Pain or Soreness _____
☐ Styes _____
☐ Flashes/Floaters _____

GASTROINTESTINAL

☐ Diarrhea _____
☐ Constipation _____

GENITOURINARY

☐ Genitals/Kidney/Bladder _____

INTEGUEMTARY (SKIN)

☐ Rosacea _____

LYMPHATIC/HEMATOLOGIC

☐ Anemia _____
☐ Bleeding Problems _____

PSYCHIATRIC

☐ Depression _____
☐ Anxiety _____
☐ ADHD _____

RESPIRATORY

☐ Asthma _____
☐ Chronic Bronchitis _____
☐ Emphysema _____

VASCULAR/CARDIO

☐ High Blood Pressure _____
☐ High Cholesterol _____
☐ Stroke _____

Any unlisted conditions: _____

☐ None of these apply to me → → Please Initial_____

Please note that if any items are left blank then you are stating that this does not apply to you.

INSURANCE SIGNATURE AND ACKNOWLEDGEMENT OF RECEIPT

I hereby give consent to DeForrest Eye Center to provide whatever treatment they may deem necessary to the patient above. I understand that I am responsible for charges incurred for services. I understand I am responsible for charges not covered by the insurance policy. I acknowledge I have received a copy of DeForrest Eye Center Notice of Privacy Practices, which outlines how my health information is utilized. I hereby request payment of authorized insurance benefits for me to be paid directly to DeForrest Eye Center for any services furnished to me by DeForrest Eye Center. I authorize DeForrest Eye Center to release to my insurance carrier and its agents any information concerning health care, advice, treatment or supplies provided me needed to determine these benefits or the benefits payable for related services. I understand this is a lifetime authorization.

Patient's Signature: _____ Date: ____/____/____

Doctor's Signature: _____ Date: ____/____/____