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Patient's Name _______________ ____________________ ____________________________
Last First Middle

Date of Birth ____/____/____ Age ______ Marital Status ________________________

Home Address_____________________________ City, State, Zip ________________________

Home Phone ___________________ Work_______________ Cell__________________________

Primary Care Provider___________________________ Phone _________________________

E-mail Address ____

Guardian Name (if applicable)____

PRIMARY

Insurance Company Name _________________ Policy #__________ Group#___________

Policy Holder Name________________________ DOB ____________ SSN# ____________

Relationship to Policy Holder *(please circle)* Self Spouse Child Other

Employer Name ___________________________ Phone # ______________________________

SECONDARY

Insurance Company Name _________________ Policy #__________ Group#___________

Policy Holder Name________________________ DOB ____________ SSN# ____________

Relationship to Policy Holder *(please circle)* Self Spouse Child Other

Employer Name ___________________________ Phone # ______________________________

In signing this document, I understand and authorize the following to be true: that a photocopy of this document is valid, this info is being used for my health or insurance billing, that I am responsible for all chargers incurred for services rendered, that I agree to pay court cost, attorney fees and related fees, should these charges be turned over to a collection agency, I will return payments if intended for this office. I authorize the release of any medical or other information necessary to process this claim, as well as payment of medical benefits and request payment of government benefits to *Wiliamson Eye Partners , PLLC*. This authorization of assignment applies to all occasions of service, until revoked by the above named person with a written statement thereof. I have read and understand the HIPPA privacy laws posted in this office or decline to review them.

X____ **Date**__________________________

Patient Medical History

Name ______________________________ **Today's Date** ______________________

Do you wear glasses ?	❒ yes	❒ no	Do you need new glasses ?	❒ yes	❒ no
Do you wear contact lenses ?	❒ yes	❒ no	Do you want us to fit you in contact lenses today ?	❒ yes	❒ no
Are you interested in LASIK ?	❒ yes	❒ no	Do you have visual difficulty when you drive ?	❒ yes	❒ no

♦ If you or a blood relative has a history of following conditions, please check the appropriate box:

	Patient	Family		Patient	Family		Patient	Family		Patient	Family
Blindness	❒	❒	Drooping Eyelid	❒	❒	Retinal Detachment	❒	❒	Heart Disease	❒	❒
Cataracts	❒	❒	Prominent Eyes	❒	❒	Arthritis	❒	❒	High Blood Pressure	❒	❒
Crossed Eyes	❒	❒	Glaucoma	❒	❒	Cancer	❒	❒	Kidney Disease	❒	❒
Lazy Eye	❒	❒	Macular Degeneration	❒	❒	Diabetes	❒	❒	Thyroid Disease	❒	❒

Are you **allergic** to any medications? ❒ Yes ❒ No—If yes, please explain ______________________________

List any **medications** you take and the reasons you take them (including over the counter medications) and any major **injuries** or **surgeries** you have had.

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♦Social History - *This information is kept strictly confidential. However, you may discuss this portion with the doctor if you prefer by checking this box.* ❒

Do you use tobacco products? ❒ yes ❒ no – If yes, type / amount / how long: ______________________________

Do you drink alcohol? ❒ yes ❒ no – If yes, type / amount / how long: ______________________________

Do you use illegal drugs? ❒ yes ❒ no – If yes, type / amount / how long: ______________________________

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

♦ Do you currently have any problems or conditions in the following areas: *(Review of Systems)*

	Yes	No		Yes	No		Yes	No		Yes	No
Fever	❒	❒	Mucous Discharge	❒	❒	Floaters- Recent Onset	❒	❒	Digestive Problems	❒	❒
Weight Loss/Gain	❒	❒	Redness of the Eye	❒	❒	Thyroid/ Other Glands	❒	❒	Genitals	❒	❒
Skin Problems	❒	❒	Sandy/Gritty Feeling	❒	❒	Allergies/ Hay Fever	❒	❒	Pregnant or Nursing	❒	❒
Recent Headaches	❒	❒	Itching Eyes	❒	❒	Chronic Congestion	❒	❒	Kidney	❒	❒
Migraines	❒	❒	Burning Eyes	❒	❒	Chronic Cough	❒	❒	Bladder	❒	❒
Blurred Vision	❒	❒	Excess Tearing/Watering	❒	❒	Dry Throat/Mouth	❒	❒	Rheumatoid Arthritis	❒	❒
Loss of Vision	❒	❒	Glare/Light Sensitivity	❒	❒	Asthma	❒	❒	Chronic Muscle Pain	❒	❒
Distorted Vision/ Halos	❒	❒	Eye Pain or Soreness	❒	❒	Chronic Bronchitis	❒	❒	Chronic Joint Pain	❒	❒
Loss of Side Vision	❒	❒	Eye Injury	❒	❒	Emphysema	❒	❒	Anemia	❒	❒
Double Vision	❒	❒	Flashes of light	❒	❒	Heart Disease	❒	❒	Bleeding Problems	❒	❒
Dryness	❒	❒	Chronic infection of Eye or Lid	❒	❒	High Blood Pressure	❒	❒	Psychiatric Problems	❒	❒

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

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❒ *If medically necessary, it is OK to dilate my eyes today.** OR ❒ *Please DO NOT dilate my eyes today*.

****NOTE: Near blurriness and light sensitivity for 2-4 hours are normal side effects of pupillary dilation.***

Patient Signature______________________ **Doctor's Signature**__________________ **Date**____________