EAST FISHKILL EYE ASSOCIATES PATIENT INFORMATION AND HISTORY

PATIENT'S NAME_____BIRTHDATE_____DATE_____

MAILING ADDRESS_____CITY_____STATE_____ZIP_____
STREET ADDRESS_____ STATUS: M__S__D__W

HOME PHONE_____CELL PHONE_____EMAIL_____
OCCUPATION_____EMPLOYER_____ PHARMACY_____

INSURED PERSON(RESPONSIBLE FOR ACCOUNT)_____PHONE #_____
RELATIONSHIP TO PATIENT_____BIRTHDATE_____SS#_____

VISION INSURANCE_____DATE OF LAST EYE EXAM_____
MEDICAL INSURANCE_____ SUBSCRIBER ID NUMBER_____

PRIMARY CARE DOCTOR_____ADDRESS_____PHONE#_____
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE_____
REASON FOR TODAYS EXAM_____

DO YOU OR ANY BLOOD RELATIVES HAVE A HISTORY OF THE FOLLOWING? CHECK THOSE THAT APPLY

IMMUNOLOGIC	**E.N.T**	**GASTROINTESTINAL**	**SKIN**	**PSYCHIATRIC**
___RHEUMATIOD ARTHRITIS	___SINUS PROB	___CROHN'S	___ECZEMA	___DEPRESSION
___LUPUS	___ALLERGIES	___COLITIS	___ROSACEA	_____OTHER
		___ULCER	___PSORIASIS	

CARDIOVASCULAR	**ENDOCRINE**	**GENITOURINARY**	**MUSCULOSKELETAL**	**RESPIRATORY**
___STROKE	___DIABETES	___HERPES SIMPLEX	___FIBROMYALGIA	___ASTHMA
___CORONARY DISEASE	___HORMONE REPL	___CHLAMYDIA	___POLYMYAL RHEUM.	___CIGARETTES
___HIGH BLOOD PRESSURE	___THYROID	_____OTHER	___OSTEOARTHRITIS	___EMPHYSEMA

CONSTITUTIONAL	**HEMATOLOGIC**	**NEUROLOGIC**	**HEADACHE**	**CANCER**
___FEVER	___ANEMIA	___MS	___MIGRAINES	___ANY TYPE
___HEAD TRAUMA		___EPILEPSY	___TENSION, OTHER	

FAMILY HISTORY OF EYE CONDITIONS ___GLAUCOMA ___CATARACTS___MACULAR DEGENERATION
___RETINAL REPAIR___LAZY EYE___HIGH EYE PRESSURE

MY CURRENT MEDICAL CONDITIONS ARE_____
MY CURRENT MEDICATIONS INCLUDING OTC ARE_____
MY KNOWN ALLERGIES ARE_____
DO YOU WORK AT A COMPUTER OR VIDEO DISPLAY TERMINAL?_____
WHAT HOBBIES OR SPORTS DO YOU ENJOY?_____
DO YOU WEAR GLASSES?_____CONTACTS_____TYPE?_____
ARE YOU INTERESTED IN INFO ABOUT LASER REFRACTIVE SURGERY?_____

MEDICAL RELEASE / LIFETIME SIGNATURE ON FILE / PAYMENT AUTHORIZATION

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS, EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ANY MATERIALS AND/OR SERVICES PROVIDED BY THE DOCTORS AND THIS OFFICE, WHICH ARE NOT REIMBURSED BY MY INSURANCE COMPANY. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORGINAL AND KEPT ON FILE.

I AUTHORIIZE PAYMENT OF MEDICAL BENEFITS TO THE PHYSICIAN OR SUPPLIER FOR THE SERVICES DESCRIBED.

SIGNED_____ DATE_____

(DOCTOR'S NOTES: LOCATION, QUALITY, SEVERITY, TIMING, CONTEXT, MODIFYING FACTORS, ASSOCIATED SIGNS, AND SYMPTOMS PATIENTS M+A + / - POTP + / -)