PATIENT INFORMATION SHEET

Last Name ______________________ First Name ______________________ Middle ____________

SSN ______________________ DOB ______________ Sex : Male / Female

Street _________________________ Apt ______ City ______________ State _____ Zip ________

Race ______________ Language ______________ Hispanic or Latino: Yes / No

Marital Status: Single / Married / Partner / Divorced / Widowed Student Status: Full Time / Part Time

CONTACT INFORMATION

Home Phone: ____________________

Day Phone: ____________________

Cell Phone: ____________________

Emergency Phone: ____________________

e-mail: ____________________

Primary Care MD: ____________________

Address: ____________________

Phone: ______________ Fax: ______________

Referring MD: ____________________

Address: ____________________

Phone: ______________ Fax: ______________

PRIMARY INSURANCE (For Personal Injury Cases, Please Ask for the Worker's Comp/MVA Form)

Payer Name: ____________________

Insured ID: ____________________

Group Number: ____________________

Specialist Co Pay: ____________________

Effective Date: ____________________

Insured Name (if not patient): ____________________

Insured DOB (if not patient): ____________________

Insured Relationship to patient: Spouse / Parent

Group Name: ____________________

Referral Required: Yes / No

SECONDARY INSURANCE

Payer Name: ____________________

Insured ID: ____________________

Group Number: ____________________

Specialist Co Pay: ____________________

Effective Date: ____________________

Insured Name (if not patient): ____________________

Insured DOB (if not patient): ____________________

Insured Relationship to patient: Spouse / Parent

Group Name: ____________________

Referral Required: Yes / No

*For Additional Insurances, Please Ask For A Second Form

Corneal Associates, P.C.

PATIENT MEDICAL HISTORY QUESTIONAIRE

Glasses wearer: yes/no **Contact Lens wearer: yes/no**

Reason for visit/consultation:____

____

ALLERGIES

Allergen	Describe Reaction

OCULAR HISTORY

Disease/Problem	Diagnosed When	Treatment ?	By Whom

SYSTEMIC MEDICAL HISTORY

Disease/Problem	Diagnosed When	Treatment ?

Corneal Associates, P.C.

Please complete this form as thoroughly as possible.

OPHTHALMIC MEDICATION

Medication	Strength	Dosage	Eye	To Treat What?

SYSTEMIC MEDICATIONS

Medication	Strength	Dosage	To Treat What?

Pharmacy Name: ______________________

Pharmacy Address: ______________________ **Fax:** __________________

Signature: ________________________________ **Date:** _______________

Corneal Associates, P.C.

If Diabetic: Recent Blood Sugar___________ When____________

FAMILY HISTORY

Family Member	Diagnosis

SOCIAL HISTORY

Do you smoke: yes/no/previously If yes, how long _______

Do you drink Alcohol: yes/no If yes, how much/frequency___________

Do your drink caffeine: yes/no If yes, how much ____________

Do you use any recreational drugs: yes/no/formerly