

PATIENT INFORMATION SHEET

(PLEASE PRINT)

MR/MRS/MS FIRST NAME _____ M.I. _____ LAST NAME _____

NAME YOU PREFER TO BE CALLED _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PHONE (HOME) _____ INSURANCE CO. _____ POLICY # _____

PHONE (WORK) _____ S.S. # _____ - _____ - _____ SEX M/F MARITAL STATUS M/S

DATE OF BIRTH _____ AGE _____
(MM/DD/YY)

EMPLOYER (SCHOOL) _____ OCCUPATION (GRADE) _____

OTHER HOUSEHOLD MEMBERS WHO ARE PATIENTS HERE _____

IF UNDER 18, NAME OF PARENT OF GUARDIAN _____

PERSON RESPONSIBLE FOR BILL _____

IF YOU WERE REFERRED, WHO MAY WE THANK FOR REFERRING YOU? _____

PLEASE NOTE: PAYMENT IS DUE WHEN SERVICES ARE RENDERED. SIGNATURE: _____

HEALTH INFORMATION

PURPOSE OF VISIT _____

LAST EYE EXAMINATION _____ BY DOCTOR _____

HEALTH HISTORY (Please check any that apply):

	SELF	BLOOD RELATIVE (RELATIONSHIP)		SELF	SELF
DIABETES	_____	_____	ALLERGIES	_____	CONVULSIONS _____
GLAUCOMA	_____	_____	CATARACTS	_____	EPILEPSY _____
HEART PROBLEMS	_____	_____	CROSSED OR LAZY EYE	_____	EYE SURGERY _____
HIGH BLOOD PRESSURE	_____	_____	EYE INJURY	_____	PREGNANT _____
THYROID	_____	_____	HEADACHES	_____	

HAVE YOU EVER WORN GLASSES? _____ BIFOCALS OR TRIFOCALS? _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDING EYE DROPS, COLD MEDICINES, BIRTH CONTROL PILLS, ETC.)

EYES EVER BEEN DILATED? _____ ANY ADVERSE REACTION _____

LIST KNOWN ALLERGIES (MEDICINE & OTHER) _____

IS THIS AN EXAM FOR NEW CONTACT LENSES? YES _____ NO _____ POSSIBLY _____

HAVE YOU EVER WORN CONTACT LENSES? _____ RIGID (HARD) OR SOFT? _____ HRS WORN PER DAY _____

DAILY OR EXTENDED WEAR? _____ WHAT SOLUTIONS? _____

MEDICARE AUTHORIZATION: I, _____, DO HEREBY AUTHORIZE DR. RUSSELL CHAMBLESS AND ASSOCIATES TO PROCESS MEDICARE CLAIMS FOR SERVICES RENDERED TO ME.

SIGNED: _____ DATE: _____ MEDICARE # _____

INCLUDE ANY LETTERS