

# PATIENT INFORMATION FORM

(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 (MM/DD/YY) \_\_\_\_\_ AGE \_\_\_\_\_

EMPLOYER (SCHOOL) \_\_\_\_\_ OCCUPATION (GRADE) \_\_\_\_\_

OTHER HOUSEHOLD MEMBERS WHO ARE PATIENTS HERE \_\_\_\_\_

IF UNDER 18, NAME OF PARENT OR GUARDIAN \_\_\_\_\_

PERSON RESPONSIBLE FOR BILL \_\_\_\_\_

IF YOU WERE REFERRED, WHOM 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 AND OTHERS) \_\_\_\_\_

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) \_\_\_\_\_