

WELCOME TO OUR PRACTICE!!

PATIENT INFORMATION

Name (Last, First, Middle Initial): _____ Date: _____

Address: _____ City, State, Zip: _____

Phone: (H) _____ (W) _____ (C) _____

Email Address: _____ Gender: M F Marital Status: S M D W

Social Sec. #: ____/____/____ Driver's Lic. #: _____ DOB: ____/____/____ Age: _____

Occupation: _____ Employer: _____

Emergency contact: _____ (H) _____ (C) _____

RESPONSIBLE PARTY (PARENT/INSURED PARTY)

If the patient is the account responsible, skip this portion.

Name of Acct. Responsible: _____ Relationship to Patient: _____

Phone: (H) _____ (W) _____ Is the account responsible a patient here? Y N

Social Sec. #: ____/____/____ DOB: ____/____/____ Employer: _____

INSURANCE INFORMATION

VISION:

Name of Insurance: _____
Insurance Type: VSP EyeMed Tricare Anthem Vision Superior Vision Other
Name of Insured: _____ DOB: ____/____/____
Identification/Policy #: _____

MEDICAL:

Name of Insurance: _____
Insurance Type: Aetna Anthem BCBS Cigna PPO/Open Access Medicare Medicaid Tricare
Name of Insured: _____ DOB: ____/____/____
Identification/Policy #: _____

NEW PATIENTS

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

Name of friend or relative: _____

IF NOT REFERRED, HOW DID YOU CHOOSE OUR OFFICE FOR YOUR OCULAR CARE? Please check the appropriate answer:

- Relative Another Doctor Saw Sign Friend Insurance List Newspaper Direct Mail
- Internet/Website **YELLOW PAGES (circle one):** Crown Point Merrillville/Hobart

Name: _____ Date: _____

REVIEW OF SYSTEMS

Do you currently, or have you ever had any medical problems in the following areas?

	<u>Yourself</u>		<u>Family</u>		<u>(list family member)</u>
Allergic/Immunologic					
Environmental Allergy	Y	N	Y	N	_____
HIV	Y	N	Y	N	_____
Rheumatoid Arthritis	Y	N	Y	N	_____
Lupus	Y	N	Y	N	_____
Cardiovascular/Vascular					
High Blood Pressure	Y	N	Y	N	_____
High Cholesterol	Y	N	Y	N	_____
Stroke	Y	N	Y	N	_____
Ear, Nose, Throat					
Upper Res. Tract Inf.	Y	N	Y	N	_____
Endocrine					
Diabetes	Y	N	Y	N	_____
Hormonal Dysfunction	Y	N	Y	N	_____
Thyroid Dysfunction	Y	N	Y	N	_____
Eyes					
Blindness of any kind	Y	N	Y	N	_____
Cataracts	Y	N	Y	N	_____
Lazy Eye/Eye Turn	Y	N	Y	N	_____
Double Vision	Y	N	Y	N	_____
Glaucoma	Y	N	Y	N	_____
Macular Degeneration	Y	N			_____
Eye Surgery	Y	N	Y	N	_____
Gastrointestinal					
Ulcers	Y	N	Y	N	_____
Digestive	Y	N	Y	N	_____
Genitourinary					
STD's	Y	N	Y	N	_____
Hematological/Lymphatic					
Anemia	Y	N	Y	N	_____
Integumentary					
Eczema	Y	N	Y	N	_____
Rosacea	Y	N			_____
Musculoskeletal					
Muscular Dystrophy	Y	N	Y	N	_____
Neurological					
Multiple Sclerosis	Y	N	Y	N	_____
Epilepsy	Y	N	Y	N	_____
Respiratory					
Asthma	Y	N	Y	N	_____
Bronchitis	Y	N	Y	N	_____
Emphysema	Y	N	Y	N	_____

Drug Allergies: (please list) _____

List of Medications: _____

Name: _____ Date: _____

OCULAR HISTORY

REASON FOR TODAY'S VISIT: Glasses Contact Lenses Emergency

Please circle if you are experiencing any of the following:

- | | | | | |
|-----------|---------------|-----------|------------------|----------------------|
| Burning | Double Vision | Headaches | Mucous Discharge | Floaters/Flashes |
| Blur | Dry Eyes | Itchiness | Redness | Bumps in/around lids |
| Eyestrain | Watery Eyes | Red Eyes | Get Sleepy | Pain |

Date of Last Eye Exam? _____

Special Visual Tasks/Hobbies/Sports: _____

GLASSES:

- Do you currently wear glasses? Y N
 Do you wear sunglasses? Y N
 How old are your glasses? _____ yrs. / mos.

CONTACT LENSES:

- Have you ever worn contact lenses? Y N
 If so, what type? (circle one) Conventional Daily Wear Extended Wear Rigid Gas Pearmeable
 Name of brand? _____
 When was the last time you wore your contacts? _____
 Are your contact lenses comfortable? Y N

LEISURE & SOCIAL HISTORY

What recreational activities do you participate in? (circle all that apply)

- | | | | | | |
|--------|-------------|--------------------|----------|--------|------------|
| Golf | Baseball | Basketball | Swimming | Sewing | Play Cards |
| Flying | Video Games | Musical Instrument | | | |

- Do you smoke? Y N If yes, how much? _____
 Do you drink alcohol? Y N If yes, how much? _____

Signature: _____ Date: _____

Acknowledgement of Receipt

I acknowledge that I received a copy of Dr. Lourdes Lorino's Notice of Privacy Practices.

Patient Name: _____

Signature: _____ Date: _____

OFFICE USE ONLY

H&P Rev. _____ Date: _____