The Lincoln Eye & Laser Institute

Patient Information Form

Title: ☐ Mr ☐ Mrs ☐ Dr ☐ Rev **Last Name:** ________________________________**First Name:** ______________________ **M.I.:** _____

Address: ____**Apt. Number:**__________

City:_____________________**State:**_____ **ZipCode:**_________ **Email address**____

Home Phone: _________________**Business Phone:**___________________**Cell phone:**_________________**Carrier**______________

We will contact you by phone/mail, please note if you have another preference_________________ **Mother's Maiden Name**__________________
(will be used to access your medical record online)

Date of Birth: _____/_____/_____ **Birth State**________ **Soc. Sec. No.:** _________-______-__________ **Marital Status: M / S/ D/ W** **Gender: M / F**

<u>Due to new government reporting regulations, we are required to ask the following questions:</u>

Race: ☐ Caucasian ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or other pacific islander ☐ Other

Primary Language:_____________________________ **Ethnicity:** ☐ Unknown ☐ Not Hispanic or latino ☐ Hispanic or latino

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How did you hear about our office? ___Optometrist ___Family doctor ___Internet ___WOM ___Newspaper ___Radio______________
(station)

___Patient____________________________ (name), ___ Employee____________________________ (name), ___Other______________________ (please list)

Who is your family physician? ____________________________ **Office Location?**_____________________________________

Who performed your last eye examination? ______________________________ **Date of last eye exam:** ___________________
Correspondence regarding your exam will be sent to your referring eye doctor/physician unless otherwise requested.

Occupation: ___________________**Employer:** ______________________________**Employer's Address:** __________________________

City, State: ____________________________________ **Is this visit a result of an accident or illness <u>that occurred at work</u>?** ☐ **Yes** ☐ **No**

Emergency Contact: ____________________ **Relationship:** ____________________ **Phone:** _____ ____________
(Not living in household)

<u>If the patient is married</u>, please complete spouse information below.

Spouse's Last Name: ______________________ **First Name:** _________________ **M.I.:**_____ **Birthdate:** _____/_____/________

Social Security Number: ______-_____-________ **Bus. Ph. No:** ______ ______________ **Occupation:** _________________________

Employer: ______________________________ **Employer's Address:** ____

<u>If insurance coverage is provided by someone other than patient or if the patient is a minor, please complete below.</u>

Insured information: **Last Name:** _________________________ **First Name:** ______________________ **M.I.:**_____

Birthdate: ______/_____/_______ **SSN:** ______-_____-_______ **Wk. Ph.:** ______ __________ **Employer:** ______________________

Who is responsible for payment after insurance? ☐ **Patient** ☐ **Patient's Father** ☐ **Patient's Mother** ☐ **Other**____________

AUTHORIZATION TO RELEASE INFORMATION TO YOUR INSURANCE COMPANY AND ACKNOWLEDGEMENT OF PERSONAL RESPONSIBILTY FOR PAYMENT

I hearby assign all medical and/or surgical benefits (to which I am entitled) to the doctor caring for me. This includes major medical benefits, Medicare, private insurance and any health plans in which I am enrolled. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not they are paid by my insurance. I hereby authorize the holder of my medical and patient registration records to release any information needed to process my insurance claims.

I understand that all balances must be paid in full within 60 days. Any balance not paid within 60 days will be charged 1.25% interest per month. A copy of my medical records can be requested in writing and will be provided to me or whomever I designate for a $15.00 processing fee.

Authorized Signature: ____ **Date of Signature:** ___________________

PLEASE FILL OUT BOTH SIDES OF SHEET

Medical History Questionnaire

Today's Date:________ Name:____ DOB:______________

What is the main reason for your visit today?

____

____

Do you have any of these eye symptoms?

□ Blurred distance vision □ Glare, halos around lights
□ Blurred reading vision □ Itching or burning eyes
□ Constant double vision □ Eye mattering or tearing
□ Flashing lights or floaters □ Foreign body sensation
□ Red Eyes □ Dry Eye □ Eye Pain

Which *eye medications* do you currently take?

□ None □ Artificial Tears

Medication Name	Amount	How many time/day
________________	_______	1 2 3 4 at bedtime
________________	_______	1 2 3 4 at bedtime
________________	_______	1 2 3 4 at bedtime

Please list any *eye surgeries* you have had:

□ None

Type of Eye Surgery	Which Eye	Year
__________________	Right Left	_____________
__________________	Right Left	_____________
__________________	Right Left	_____________
__________________	Right Left	_____________

Do you have any allergies to any medications?

□ None known □ Yes, which ones? (list below)

Medication Name	What reaction did you have?
__________________	__________________________
__________________	__________________________
__________________	__________________________
__________________	__________________________

Which *other* medications do you currently take?

□ None □ Aspirin on a daily basis

Medication Name	Amount	How many times/day
_____________________	_______	1 2 3 4 at bedtime
_____________________	_______	1 2 3 4 at bedtime
_____________________	_______	1 2 3 4 at bedtime
_____________________	_______	1 2 3 4 at bedtime
_____________________	_______	1 2 3 4 at bedtime
_____________________	_______	1 2 3 4 at bedtime
_____________________	_______	1 2 3 4 at bedtime
_____________________	_______	1 2 3 4 at bedtime
_____________________	_______	1 2 3 4 at bedtime
_____________________	_______	1 2 3 4 at bedtime

Please list *other* surgeries you have had:

□ None

Type of surgery	Year
______________________________	_______
______________________________	_______
______________________________	_______
______________________________	_______

Have you ever had any of these conditions?

□ None
□ Stroke □ Dizziness □ Arthritis □ Allergies
□ High blood pressure □ Heart disease
□ Diabetes □ AIDS, HIV □ Lung diseases
□ Cancer □ Anemia □ Thyroid disease
□ Headaches □ Other:____________________

____

Have you ever had any of these *eye* problems?

□ Cataract □ Glaucoma □ Macular Degeneration
□ Retinal detachment □ Iritis/uveitis □ Lazy eye
□ Serious eye injury □ Wore eye patch as a child

Are you allergic to LATEX? Yes / No
Do you have a history of MRSA? Yes / No

Do you use? □ Tobacco □ Alcohol

Have any family members had any *eye* diseases?
(father, mother, sister, brother, grandparents)

□ Cataract □ Glaucoma □ Macular Degeneration
□ Diabetic eye disease or diabetes □ Poor vision
□ Retinal detachment □ Iritis/uveitis □ Blindness
□ Crossed eyes □ Other:_____________________

Review of Systems: *Do you currently have any of the following problems?*

	Y	N
Chronic fever, unexpected wt. loss/gain…	□	□
Ear/nose/throat (hearing loss, sinus, throat)	□	□
Heart (chest pain, irregular heart beat)	□	□
Respiratory (shortness of breath, coughing)	□	□
Gastrointestinal (heartburn, diarrhea, vomit.)	□	□
Urine (pain, blood in urine)	□	□
Skin (rashes, excessive dryness)	□	□
Musculoskeletal (muscle aches, joint pain)	□	□
Neurologic (numbness, weakness, headache)	□	□
Psychiatric (depression, anxiety)	□	□