The Omaha Eye & Laser Institute

Patient Information Form

Title:_____ Legal Last Name: _____ Legal First Name: _____ M.I.: _____

Address: _____Apt. Number:_____

City:_____State:_____ ZipCode:_____ Email address_____

Home Phone: _____Business Phone:_____Cell phone:_____Carrier_____

Preference of communication: ☐ Phone ☐ US Mail ☐ Email ☐ Text **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

Due to new government reporting regulations, we are required to ask the following questions:

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_____, ___ Employee_____, ___Other_____
(name) (name) (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: _____ _____
(Must be different from home number)

<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 for a processing fee not to exceed $0.50 per page.

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)	□	□