The Omaha Eye & Laser Institute

Patient Information Form

Title:______ **Legal Last Name:** ______________________________ **Legal First Name:** ____________________ **M.I.:** ___________

Address: ____ **Apt. Number:**_______________

City:____________________ **State:**_____ **ZipCode:**_________ **Preference of communication:** ☐ Phone ☐ US Mail ☐ Email

Home Phone: _________________________ **Business Phone:**_______________________ **Cell phone:**___________________________

Email address____ **(will be used to access your medical record online through the patient portal)**

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**

How did you hear about our office? Optometrist ____Family doctor ____Internet ____Radio______ Other_______________________

Patient referred by____________________________________ Employee___________________________________
(name) (name)

Who is your family physician? _________________________ **Office Location?**___________________________________

Who performed your last eye examination? _____________________________ **Office Location/Exam Date:** __________________

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 that occurred at work?** ☐ **Yes** ☐ **No**

Emergency Contact: ___________________ **Relationship:** ___________________ **Phone:** _____ __________
(Must be different from home number)

If the patient is married, 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:** ____

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

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. Please be aware that overdue accounts will be considered for collections and will terminate our doctor-patient relationship. 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, and a handling fee not to exceed $15.00.

Authorized Signature: ____ Date of Signature: ________________

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)	□	□