

Welcome to Our Office

This information will allow us to begin the process that ensures your eye health and vision remain at their best, and that your health and lifestyle needs are met. Thank you for your help.

Miss/Mrs./Ms.
Name Mr. _____
Dr./Rev. Last First Middle Nickname or Preferred

Address _____
Street or P.O. Box City State Zip

Date of Birth ____/____/____ SS# ____-____-____ Gender: M F Preferred language _____

Race _____ Ethnicity: Hispanic Non-Hispanic Decline to provide (*Some ethnic groups are more at risk for eye disease.*)

Phone numbers cell (____) ____-____ home (____) ____-____ work (____) ____-____

E-mail _____ Text messaging okay? Y N

NOTE: All patient information is kept strictly confidential. Your address is NEVER shared.

Preferred method of communication: Email Postal mail Telephone (Cell, Home or Work) Text message

Employer _____ Occupation _____

If student, grade level _____ School _____ Teacher _____

If married, name of spouse _____ Spouse employed by _____

If under 18, parent or guardian's name _____

Relation _____ Phone (____) - _____ Employer _____

Reason for today's visit _____ Who may we thank for referring you? _____

Primary insurance carrier _____ Insured's name _____

ID number _____ Insured's Birth date _____

Insured's address: Same as patient or _____

Insured's Employer _____ Patient relationship to Insured: Self Spouse Child Other

Secondary insurance carrier _____ Insured's name _____

ID number _____ Insured's Birth date _____

Insured's address: Same as patient or _____

Insured's Employer _____ Patient relationship to Insured: Self Spouse Child Other

How will you be paying today? Full payment by cash, check, or credit card Insurance with deductible/co-pay

"I request that payment of authorized insurance benefits be made to Taylor Eye Associates, PLLC for any services provided. I also authorize any holder of medical information about me to release to the carrier and its agents any information needed to determine these benefits or the benefits payable for related services."

"I understand that any charges not covered by insurance and co-pays are due at time of service."

"I also acknowledge that I have had an opportunity to receive a copy of the Privacy Practices and Policies of this practice."

Signature Date

MEDICAL HISTORY QUESTIONNAIRE

Patient name _____ Exam Date _____

Medical Doctor's Name _____ Date of last medical exam _____

Last Eye Doctor's Name _____ Date of last eye exam _____

Your preferred pharmacy _____ Where is it located? _____

Do you **currently** have any problems in the following areas? If YES, please provide additional information.

EYES (poor vision, eye pain, tearing, redness, etc.): Y N _____

ALLERGY (seasonal, environmental): Y N _____

CARDIOVASCULAR (blood pressure, cholesterol, heart disease, etc.): Y N _____

CONSTITUTIONAL (fever, weakness, weight loss/gain, etc.): Y N _____

HEIGHT _____ ft. _____ in. **WEIGHT** _____ lbs.

ENDOCRINE (diabetes, thyroid, etc.): Y N _____

GASTROINTESTINAL (diarrhea, constipation, hernia, ulcers, etc.): Y N _____

GENITOURINARY (painful/frequent urination, impotence, jaundice, etc.): Y N _____

FEMALES: Are you pregnant? Y N If yes, number of weeks _____ Are you nursing? Y N

EAR/NOSE/MOUTH/THROAT (hard of hearing, cough, dry mouth, etc.): Y N _____

BLOOD/LYMPH (bleeding, anemia, transfusion, etc.): Y N _____

IMMUNOLOGIC (Lyme disease, HIV/AIDS, etc.): Y N _____

SKIN (pimples, warts, growths, rash, etc.): Y N _____

MUSCLES/BONES/JOINTS (joint pain/stiffness, cramps, arthritis, etc.): Y N _____

NEUROLOGICAL (headache, seizures, paralysis, etc.): Y N _____

PSYCHIATRIC (anxiety, depression, bipolar disorder, etc.): Y N _____

Please list any **medications** (prescription and over-the-counter) you are currently taking: _____

Please list any **allergies to medications**: _____

Please list any **surgeries**: _____

Please list any **injuries**: _____

SMOKING STATUS: (please circle) Never smoked Former smoker (how long ago did you stop? _____)

Current smoker (packs per day _____ number of years _____) Smokeless tobacco

ALCOHOL USE: Y N If YES, how much? _____ **NARCOTIC USE:** Y N

SEXUALLY TRANSMITTED DISEASE: Y N **BLOOD TRANSFUSION:** Y N

FAMILY HISTORY: Has any member of your family (blood relative) had any of the following diseases? **Glaucoma, Cataract, Macular Degeneration, Blindness, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Arthritis, Thyroid disease**

If YES, then please provide details: _____

***Dilation drops are used during the eye exam. If you have any questions, please ask our staff or the doctor.*

Physician's signature _____ **Date** _____