EYECARE ROCKWALL

PATIENT DEMOGRAPHIC

Today's Date: _____ / _____ / _____ Name: _____ Sex: M F

What name should we use to address you? _____ Birth Date _____ / _____ / _____ Age: _____

Ethnicity __ Hispanic or Latino __Native Hawaiian / Other Pacific Island __Not Hispanic or Latino **Race** __American Indian __Asian __Black / African American __Hispanic __Hawaiian / Other Pacific Island __White **Marital Status** __Single __Never Married __Married __Divorced __Widowed

Preferred Language __English __Spanish **Communication Preference** __Phone __E-mail __Text __Mail

Address: _____ City: _____ State: _____

Zip Code: _____ Home ph#: _____ Work ph# _____ Cell ph# _____

SSN: _____ Driver's Lic # _____ State: _____ Expiration _____

E-mail address: _____ Employer: _____

Occupation: _____ Emergency Contact: _____ Ph#: _____

REGARDING INSURANCE

Our office is pleased to assist you in filling claims with your insurance company for the reimbursement of these expenses. ***The patient is responsible for knowing what your insurance does or does not cover.***

The patient is responsible to pay any deductible and co-payments at the time services are rendered.
Any portion of the billed amount that is not covered by your insurance will become the patient's responsibility.
Our office NEVER guarantees that your insurance will pay for services rendered.
Not all services are covered by your insurance.
If you request a check for credit on your account you will need to pick up the check in office and sign for it

Insurance Company: _____ Primary Insured Name: _____

Policy Holder's DOB: _____ / _____ / _____ ID#: _____ Group#: _____

Insurance ph#: _____

MEDICAL HISTORY

Name of Primary Physician: _____ Dr's Ph#: _____

Do you have allergies to medications? If so, please list: _____

List any medications you take including oral contraceptives, aspirin, and/or over-the-counter medications:

_____

_____

_____

Are you pregnant or nursing? Y N Do you become weak or faint with dental work, shots or giving blood? Y N

Any family history of the following?	**Diabetes**	**Y**	**N**	**If so, what relation? _____**
	Heart disease	**Y**	**N**	**If so, what relation? _____**
	High blood pressure	**Y**	**N**	**If so, what relation? _____**
	High cholesterol	**Y**	**N**	**If so, what relation? _____**
	Kidney disease	**Y**	**N**	**If so, what relation? _____**
	Lupus	**Y**	**N**	**If so, what relation? _____**
	Thyroid disease	**Y**	**N**	**If so, what relation? _____**

please see reverse side for continuation of medical history

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SOCIAL HISTORY *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

___ Yes, I would prefer to discuss my social history information with my doctor.

Do you use tobacco products? Y N **If yes, type/ amount/ how long?** _____

Do you drink alcohol? Y N **If yes, type/ amount/ how long?** _____

Do you use illegal drugs? Y N **If yes, type/ amount/ how long?** _____

Have you ever been diagnosed and / or treated for: ___ Gonorrhea ___ Hepatitis ___ HIV ___ Syphilis ___ Herpes I / II

REVIEW OF SYSTEMS

EYES			**INTEGUMENTARY (skin)**			Emphysema	Y	N
Loss of vision	Y	N	Adult acne (Rosacea)	Y	N	**CARDIOVASCULAR**		
Blurred vision	Y	N	**NEUROLOGICAL**			Heart pain	Y	N
Distorted vision / halos	Y	N	Headaches	Y	N	High blood pressure	Y	N
Double vision	Y	N	Migraines	Y	N	Vascular disease	Y	N
Dryness	Y	N	Seizures	Y	N	**GASTROINTESTINAL**		
Mucous discharge	Y	N	**ENDOCRINE**			Diarrhea	Y	N
Redness	Y	N	Thyroid/other glands	Y	N	Constipation	Y	N
Sandy of gritty feeling	Y	N	Diabetes	Y	N	Gastric bypass / reflux	Y	N
Itching	Y	N	**PSYCHIATRIC**			**GENITOURINARY**		
Burning	Y	N	Anxiety	Y	N	Genitals / kidney / bladder	Y	N
Foreign body sensation	y	N	Depression	Y	N	**BONES, JOINTS, MUSCLES**		
Excess tearing / watering	Y	N	**EARS, NOSE MOUTH, THROAT**			Rheumatoid arthritis	Y	N
Glare / light sensitivity	Y	N	Allergies / hay fever	Y	N	Muscle pain	Y	N
Eye pain	Y	N	Sinus congestion	Y	N	Joint pain	Y	N
Flashes or floaters	Y	N	Chronic cough	Y	N	**LYMPHATIC / HEMATOLOGIC**		
Tired Eyes	Y	N	Dry mouth / throat	Y	N	Anemia	Y	N
CONSTITUTIONAL			**RESPIRATORY**			Blood clotting disorder	Y	N
Fever	Y	N	Asthma	Y	N	**ALLERGIES / IMMUNOLOGIC**		
Weight loss / gain	Y	N	Chronic bronchitis	Y	N	Environmental	Y	N
						Medical	Y	N

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

_____

_____

OCULAR HISTORY **When was your last eye examination?** _____ **Where?** _____

Do you wear glasses? Y N **If yes, how old is your latest pair?** _____

Have you had any eye surgeries? Y N **If yes, please list:** _____

Do you wear contact lenses? Y N **If yes, please state brand:** _____

Type of contact lenses: **Rigid Soft Toric Bifocal Other**

Replacement schedule: **Daily disposable Two week One month Other** _____

Wear schedule: **Daily only Occasional over-night Extended wear**

Any family history of blindness, glaucoma, macular degeneration, or retinal detachments? If so, please detail:

_____

_____

_____

Patient signature: _____ ***Date:*** _____