WILDA EYE CARE

Date _____ **PATIENT INFORMATION FORM**

Last name _____
First name _____
Middle Initial _____
Title: Dr. / Mr. / Mrs. / Ms. / Miss
Suffix: Jr. / Sr. / II / III / IV
Nickname _____
Address _____
City _____
State _____ Zip Code _____
Home Phone # _____
Daytime Phone # _____
Cell Phone # _____
May we text you? Yes / No
Pager # _____
Fax # _____
May we contact you by email? Yes / No
Email address _____

Gender: M / F Date of Birth _____
Social Security # _____
Employer _____
Occupation _____

Name of Spouse (Name of parent/guardian if minor)
_____

The following information helps our office comply with Meaningful Use with regards to insurance filing.
Preferred Language: English / Spanish
Race: White/ African Amer. /Hispanic or Latino/Native Amer.
Ethnicity:White/ African Amer. /Hispanic or Latino/Native Amer.
Communication Preferred: Email / Postal / Telephone

Referred by _____

Do you have **VISION** Insurance? Yes / No
If yes, insurance name:
_____
Insured ID #: _____
Plan Name:
_____
Policy Group #:
_____
Relationship to Insured: _____
Insured's Name: _____
Insured's DOB: _____ Telephone: _____

Do you have **MEDICAL** Insurance: Yes / No
If yes, insurance name:
_____
Insured ID #: _____
Plan Name:
_____
Policy Group #:
_____
Relationship to Insured: _____
Insured's Address: _____
_____

PERSONAL EYE HISTORY

Date of last eye examination: _____ Name of last Optometrist/Ophthalmologist: _____

Are you currently under the care of an Ophthalmologist? Yes / No If yes, explain: _____

Have you had eye surgeries/injuries? Yes / No If yes, explain: _____

Do you wear glasses? Yes / No If yes, how old is your current pair of lenses? _____
Do you wear contact lenses? Yes / No If yes, how old is your current pair of lenses? _____
Type of contact lenses worn: Rigid / Soft / Extended wear (sleep in) Are they comfortable? Yes / No
Do you have questions regarding LASIK eye surgery? Yes / No

Please turn over form and complete the second page.

MEDICAL INFORMATION

Date of last medical examination _____ Name of Medical Doctor _____
List any medications you take (including oral contraceptives, aspirin, and over the counter meds). _____
_____
_____
Do you have any allergies? Yes / No If yes, explain _____
Do you have any allergies to medication? Yes / No If yes, explain _____
List all major injuries, surgeries and/or hospitalizations you have had _____
_____
Are you nursing and/or pregnant? Yes / No

REVIEW OF SYPMTOMS

Please put a check mark if you/family member currently or have ever had any problems in the following areas?

	Self/Family		**Self**/Family
Glaucoma	___ /___	Asthma	___ /___
Cataracts	___ /___	Diabetes	___ /___
Crossed Eyes	___ /___	Heart Disease	___ /___
Macular Degeneration	___ /___	High Blood Pressure	___ /___
Retinal Detachment	___ /___	Kidney Disease	___ /___
Retinal Disease	___ /___	Lupus	___ /___
Arthritis	___ /___	Thyroid Disease	___ /___
Cancer	___ /___	Other	_____

Please note any family history (parents, grandparents, siblings, children; living or deceased)

SOCIAL HISTORY

Do you use tobacco products? Yes / No If yes, amount _____ # of Years _____
Alcohol? Yes / No Other substances? Yes / No If yes, please list: _____
Have you ever been exposed to or infected with HIV / Hepatitis / Gonorrhea / Syphilis
If yes, please explain _____
Have you ever had a blood transfusion? Yes / No

ACKNOWLEDGEMENT OF REVIEW RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I read &/or received a copy of Stacey L. Wilda O.D's Notice of Privacy Practices

Signature_____**Date**_____

Please list any person(s) authorized to obtain information regarding your medical records below:

_____