Welcome to our Office....

Today's Date_____

□ Dr. □ Mr. □ Mrs. □ Ms. □ Child

First & Last Name _____

Nickname/Preferred Name _____

Mailing Address _____

City_____ State _____ Zip_____

Social Security Number_____

Email Address _____

Sex □ M □ F Age____ Date of Birth _____

Ethnicity _____

Occupation _____

Patient Employer/School _____

Spouse (or Parent) Name_____

Who may we thank for recommending you to us_____

_____

PHONE NUMBERS

Home (____)_____ Cell (___)_____

Work Phone (_____)_____ Ext _____

Spouse's Phone (____) _____

Texting okay? □ Yes □ No

_____

In Case of Emergency:

Name_____

Relationship_____

Home (___)_____ Cell (___)_____

Work Phone (___)_____ Ext _____

Primary Care Physician's Name:

_____

Date of last visit_____

Phone Number _____

Address_____

Last Vision Care: _____

Date of last eye exam _____

Name of Doctor_____

List any eye surgery you have had: _____

_____

_____

List any other surgeries you have had: _____

_____

INSURANCE:

Who is responsible for this account? _____

Relationship to this patient? _____

Policyholder's Name_____

Employer_____

Birth date_____ SS# _____

Insurance Co. _____

Group#_____

Is patient covered by additional insurance? □ Yes □ No

Secondary Insurance_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependents(s), have insurance coverage

Name of Insurance Company(ies)

with _____

And assign directly to Dr. Koshuta/Dr. Samuel all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctors may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____

Signature of Patient, Parent, Guardian or Personal Representative

_____

Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____

Date Relationship to Patient

GLASSES / CONTACTS:

Do you wear glasses? □ Yes □ No

□ All the time □ Occasionally
□ Reading □ Driving □ TV

Do you wear contacts? □ Yes □ No
Type_____ Hours/Day_____

Describe any problems you have with your contacts:
_____

Hobbies:_____

_____

HEALTH HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following. Also, place a mark to indicate if a blood relative has had any of the following problems, and **DOCUMENT IF IT WAS MOTHER, FATHER, SISTER, BROTHER, MATERNAL/PATERNAL GRANDPARENTS, AUNT, UNCLE OR CHILD.**

	Self	Relative
Allergy:		
Seasonal / Environmental	□ Yes □ No	□ Yes_____
Other: _____	□ Yes □ No	□ Yes_____
Cardiovascular:		
Heart Condition	□ Yes □ No	□ Yes_____
High Blood Pressure	□ Yes □ No	□ Yes_____
Stroke	□ Yes □ No	□ Yes_____
Elevated Cholesterol	□ Yes □ No	□ Yes_____
Endocrine:		
Diabetes (Type_____)	□ Yes □ No	□ Yes_____
Thyroid Condition	□ Yes □ No	□ Yes_____
Kidney (Renal) Disease	□ Yes □ No	□ Yes_____
Other: _____	□ Yes □ No	□ Yes_____
Gastrointestinal:		
Hepatitis (Type _____)	□ Yes □ No	□ Yes_____
Other: _____	□ Yes □ No	□ Yes_____
Genitourinary (Urinary):		
STD (Type _____)	□ Yes □ No	□ Yes_____
Other: _____	□ Yes □ No	□ Yes_____
Hematologic/Lymphatic:		
Cancer (Type _____)	□ Yes □ No	□ Yes_____
Blood transfusions	□ Yes □ No	□ Yes_____
Bleeding Problems	□ Yes □ No	□ Yes_____
Other: _____	□ Yes □ No	□ Yes_____
Immunologic:		
AIDS/ HIV	□ Yes □ No	□ Yes_____
Tuberculosis	□ Yes □ No	□ Yes_____
Rheumatic Fever	□ Yes □ No	□ Yes_____
Lupus	□ Yes □ No	□ Yes_____
Other: _____	□ Yes □ No	□ Yes_____

	Self	Relative
Integumentary:		
Acne Rosacea	□ Yes □ No	□ Yes_____
Ocular Rosacea	□ Yes □ No	□ Yes_____
Psoriasis	□ Yes □ No	□ Yes_____
Shingles	□ Yes □ No	□ Yes_____
Other: _____	□ Yes □ No	□ Yes_____
Musculoskeletal:		
Arthritis (Type _____)	□ Yes □ No	□ Yes_____
Spondylitis (Type _____)	□ Yes □ No	□ Yes_____
Other: _____	□ Yes □ No	□ Yes_____
Neurological:		
Migraine Headaches	□ Yes □ No	□ Yes_____
Headaches (other)	□ Yes □ No	□ Yes_____
Multiple Sclerosis	□ Yes □ No	□ Yes_____
Epilepsy	□ Yes □ No	□ Yes_____
Other: _____	□ Yes □ No	□ Yes_____
Psychiatric:		
Other: _____	□ Yes □ No	□ Yes_____
Respiratory:		
Asthma	□ Yes □ No	□ Yes_____
Emphysema	□ Yes □ No	□ Yes_____
COPD	□ Yes □ No	□ Yes_____
Other: _____	□ Yes □ No	□ Yes_____
Tobacco use:	□ Yes □ No	
□ Former □ Every day □ Some day		
□ Heavy □ Light □ Smokeless tobacco		
Packs a day_____ Years smoking_____		
Alcohol	□ Yes □ No	
Are you pregnant?	□ Yes □ No	
Number of children _____		
Breastfeeding	□ Yes □ No	

Place a mark on "Yes" or "No" to indicate if you or a relative have any of the following:

	Self	Relative
Cataracts	□ Yes □ No	□ Yes_____
Macular Degeneration	□ Yes □ No	□ Yes_____
Crossed /Lazy Eyes	□ Yes □ No	
Double Vision	□ Yes □ No	
Dry Eyes/Watering	□ Yes □ No	
Eye Injury	□ Yes □ No	
Eye Strain	□ Yes □ No	

	Self	Relative
Eye Surgery	□ Yes □ No	□ Yes_____
Floaters or Spots	□ Yes □ No	
Glaucoma	□ Yes □ No	□ Yes_____
Headaches	□ Yes □ No	
Loss of Vision	□ Yes □ No	□ Yes_____
Light Sensitive	□ Yes □ No	
Retinal Disease	□ Yes □ No	□ Yes_____

MEDICATIONS

List any medications you are currently taking, including eye drops_____

_____

_____

_____

_____

_____

Pharmacy Name _____

Phone (_____) _____

ALLERGIES

List your allergies to medications or other substances:

_____

_____

_____

_____

_____

_____

_____