Today's Date _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Gender: Male/Female SSN: ____-____-_____ Date of Birth: ____/____/____ Age: _____

Mailing Address _____ City/State_____ Zip _____

Home # _____ Cell # _____ Work # _____

Email: _____ Race: _____

Employer: _____ Occupation: _____

Marital Status: S/M/D/W Spouse's Name _____

Emergency Contact:_____ Phone # _____ Relationship: _____

INSURANCE INFORMATION

Vision Insurance: _____ Medical Insurance: _____

Subscriber's Name: _____Relationship to Patient: _____

Subscriber's SSN:____-____-_____ Date of Birth: ____/____/____ Employer: _____

ASSIGNMENT OF BENEFITS

I understand that my signature requests that payments from my insurance be made directly to the above named facility. I further authorize the release of any necessary information, including medical information, for the payment of this or any related claim.

Patient's Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for your services, and to conduct healthcare operations involving our office. The Notice of Privacy Practices you have been given describes these uses and disclosures in detail.

I acknowledge that I have received the Notice of Privacy Practices from Pauls Valley Eye Clinic.

Patient's Signature: _____ Date: _____

(Over)

Personal Medical History

Height: _____ Weight: _____

Name of Medical Doctor: _____ Location of Medical Doctor: _____

Please List or Circle General Health Condition(s): _____

_____

Diabetes / Hypertension / Stroke / Cancer / Lupus / Heart Disease / Kidney Disease / Thyroid Disease / **Seasonal Allergies**

Please List or Circle Eye Health Condition(s): _____

Glaucoma / Cataracts / Macular Degeneration / Color Blindness / Retinal Detachment / Blindness

Please List All General Health Surgeries: _____

Please List or Circle All Eye Surgeries: _____

Cataract Surgery / Lasik Surgery Right Eye - Date:_____ Left Eye - Date:_____

Current Medication(s) — (prescription or over-the-counter) If you have a med list with you, please provide so we may make a copy.

_____

Current Eye Medication(s) - (prescription or over-the-counter)

Name(s): _____ How often? _____

Drug Allergies? Yes / No If yes, please list:_____

Pharmacy: _____

Are you allergic to Latex Yes / No Adhesive Yes / No

Family Medical History

Please List or Circle All That Apply: _____

Glaucoma / Cataracts / Macular Degeneration / Color Blindness / Retinal Detachment / Blindness

Diabetes / Hypertension / Stroke / Cancer / Lupus / Heart Disease / Kidney Disease / Thyroid Disease

Social History – Please circle

Tobacco Use: Never Smoked / Former Smoker / Current Everyday Smoker when did you quit?_____

What kind of tobacco products do you use? Smokeless / Vape / Cigarettes

Alcohol Use? Yes / No If yes, how often? 1-2 drinks per day / Social use / Dependent

Narcotic Use? Yes / No If yes, how often? Recreational / Dependent

Cannabis Use? Yes / No If yes, how often? Recreational / Dependent

Have you ever had a blood transfusion? Yes / No When? _____

AIDS/HIV: Yes / No

Patient's Signature: _____