

## 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."

Signature \_\_\_\_\_

Date \_\_\_\_\_

"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 \_\_\_\_\_

**RESPIRATORY** (congestion, wheezing, short of breath, etc.): Y N \_\_\_\_\_

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

**MEDICATION ALLERGIES:** Y N \_\_\_\_\_

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** \_\_\_\_\_