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.

Name Miss/Mrs./Ms. 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/Latino Not Hispanic/Latino Native Hawaiian/Other Pacific Islander Decline to provide

Phone numbers home (_____) _____-_____ work (____) _____-_____ cell (____) _____-_____

E-mail_____ Text messaging okay? Y N

Preferred method of communication: Email Postal mail Telephone

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 _____

MEDICATIONS (prescription and/or over-the-counter): Y N _____

_____

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** _____