The Lincoln Eye & Laser Institute

Patient Information Form

Title:_______ **Legal Last Name:** ________________________________ **Legal First Name:** ______________________ **M.I.:** ____________

Address: ____**Apt. Number:**_________________

City:______________________**State:**_____ **ZipCode:**__________ **Preference of communication:** Phone US Mail Email

Home Phone: ___________________________**Business Phone:**_________________________**Cell phone:**_______________________________

Patient Portal: (will be used to access your medical record online) **Email address**____

Date of Birth: _____/_____/_____ **Birth State**______ **Soc. Sec. No.:** _________-______-___________ **Marital Status: M / S/ D/ W** **Gender: M / F**

Due to new government reporting regulations, we are required to ask the following questions:

Race: Caucasian Black or African American Asian American Indian or Alaska Native Native Hawaiian or other pacific islander Other

Primary Language:________________________________ **Ethnicity:** **Unknown** **Not Hispanic or latino** **Hispanic or latino**

How did you hear about our office? ___Optometrist ___Family doctor ___Internet ___WOM ___Newspaper ___Radio______________ (station)

___Patient_____________________________ (name), ___ Employee_____________________________ (name), ___Other________________________ (please list)

Who is your family physician? ______________________________ **Office Location?**____

Who performed your last eye examination? __________________________________ **Office Location/Exam Date:** _____________________

Correspondence regarding your exam will be sent to your referring eye doctor/physician unless otherwise requested.

Occupation: ____________________**Employer:** ____________________________________**Employer's Address:** _____________________________

City, State: ____ **Is this visit a result of an accident or illness that occurred at work?** **Yes** **No**

Emergency Contact: ______________________ **Relationship:** ______________________ **Phone:** _____ _____________
(Must be different from home number)

If the patient is married, please complete spouse information below.

Spouse's Last Name: _________________________ **First Name:** ___________________ **M.I.:**_____ **Birthdate:** _____/_____/________

Social Security Number: ______-_____-________ **Bus. Ph. No:** ______ ______________ **Occupation:** ____________________________

Employer: _________________________________ **Employer's Address:** ____

If insurance coverage is provided by someone other than patient or if the patient is a minor, please complete below.

Insured information: **Last Name:** ___________________________ **First Name:** _________________________ **M.I.:**_____

Birthdate: ______/_____/_______ **SSN:** ______-_____-_______ **Wk. Ph.:** ______ __________ **Employer:** ________________________

Who is responsible for payment after insurance? **Patient** **Patient's Father** **Patient's Mother** **Other**_____________

AUTHORIZATION TO RELEASE INFORMATION TO YOUR INSURANCE COMPANY AND ACKNOWLEDGEMENT OF PERSONAL RESPONSIBILTY FOR PAYMENT

I hearby assign all medical and/or surgical benefits (to which I am entitled) to the doctor caring for me. This includes major medical benefits, Medicare, private insurance and any health plans in which I am enrolled. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not they are paid by my insurance. I hereby authorize the holder of my medical and patient registration records to release any information needed to process my insurance claims. I understand that all balances must be paid in full within 60 days. Any balance not paid within 60 days will be charged 1.25% interest per month. Please be aware that overdue accounts will be considered for collections and will terminate our doctor-patient relationship. A copy of my medical records can be requested in writing and will be provided to me or whomever for a processing fee not to exceed $0.50 per page, and a handling fee not to exceed $15.00.

Authorized Signature: ____ Date of Signature: ____________________

PLEASE FILL OUT BOTH SIDES OF SHEET

Medical History Questionnaire

Today's Date:____________ Name:____ DOB:_____________

What is the main reason for your visit today?

____

____

Do you have any of these eye symptoms?

□ Blurred distance vision □ Glare, halos around lights
□ Blurred reading vision □ Itching or burning eyes
□ Constant double vision □ Eye mattering or tearing
□ Flashing lights or floaters □ Foreign body sensation
□ Difficulty driving at night or driving facing the sun
□ Film/fog over your vision □ Eye Pain
□ Red Eyes □ Dry Eye
□ Difficulty performing up close activities such as reading the newspaper etc.

Which *eye medications* do you currently take?

□ None □ Artificial Tears

Medication Name	Amount	How many time/day
_______________	_______	1 2 3 4 at bedtime
_______________	_______	1 2 3 4 at bedtime
_______________	_______	1 2 3 4 at bedtime

Please list any *eye surgeries* you have had:

□ None

Type of Eye Surgery	Which Eye	Year
_________________	Right Left	____________
_________________	Right Left	____________
_________________	Right Left	____________
_________________	Right Left	____________

Have you ever had any of these *eye* problems?

□ Cataract □ Glaucoma □ Macular Degeneration
□ Retinal detachment □ Iritis/uveitis □ Lazy eye
□ Serious eye injury □ Wore eye patch as a child
□ Ocular Hypertension □ Retinal tear

Any family members with any *eye* diseases? If so, Please indicate which person (father, mother, sister, brother, grandparent, children)

□ Cataract: _________________________________
□ Glaucoma: ________________________________
□ Retinal detachment: _______________________
□ Macular Degeneration: _____________________
□ Other: ____________________________________

Do you take, or have you ever taken Flomax/Tamsulosin? Yes / No

Please list *other* surgeries you have had:

□ None

Type of surgery	Year
______________________________	_______
______________________________	_______
______________________________	_______
______________________________	_______

Have you ever had any of these conditions?

□ None □ Anxiety □ Arthritis □ Asthma
□ Congestive heart failure □ Cancer: ___________
□ Dizziness □ Dementia □ Diabetes, Type 1 or 2?
□ Eczema □ Heart attack □ Heart disease
□ High blood pressure □ High cholesterol
□ Lung diseases □ Stroke □ Thyroid disease
□ AIDS, HIV □ Other: ______________________

Review of Systems: *Do you currently have any of the following problems?*

	Y	***N***
Chronic fever, unexpected wt. loss/gain…	□	□
Ear/nose/throat (hearing loss, sinus, throat)	□	□
Heart (chest pain, irregular heart beat)	□	□
Respiratory (shortness of breath, coughing)	□	□
Gastrointestinal (heartburn, diarrhea, vomit.)	□	□
Urine (pain, blood in urine)	□	□
Skin (rashes, excessive dryness)	□	□
Neurologic (numbness, weakness, headache)	□	□
Musculoskeletal (muscle aches, joint pain)	□	□
Psychiatric (depression, anxiety)	□	□

Are you allergic to LATEX? Yes / No
Do you have a history of MRSA? Yes / No

Do you currently use? □ Tobacco □ Alcohol
If yes to tobacco, what type? Cigarettes or Chew
How often?______________________________
Are you a former smoker? Yes / No

Do you have any allergies to any medications?

□ None known □ Yes, which ones? (list below)

Medication Name	What reaction did you have?
_________________	_______________________
_________________	_______________________
_________________	_______________________

Influenza Immunization (in last 12 months) Yes/No
Pneumonia Vaccination (in last 12 months) Yes/No

Are you Pregnant?__________ Nursing?_________