

Patient Information					Please Print
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Last Name	First Name	M.I.	Social Security Number	Sex	Date
Address			City	State	Zip
Home Phone	Work Phone	Cell Phone	Age	Date of Birth	Marital Status
Occupation	Patient's Employer	Employer's Address			
Next of Kin	Phone	Address	E-Mail Address		

If the patient is a minor, please complete this section
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Father's Name	Social Security Number	Work Phone
Employer's Name	Employer's Address	
Mother's Name	Social Security Number	Work Phone
Employer's Name	Employer's Address	

Insurance Information (Please present your insurance card or referral to the receptionist)

Primary Insurance Company		
Insured's Name	Policy Number	Group Number
Insured's Date of Birth	Relationship to Patient	
Insurance Company's Address		
Secondary Insurance Company		
Insured's Name	Policy Number	Group Number
Insured's Date of Birth	Relationship to Patient	
Insurance Company's Address		

Authorization for Medical Care and Notice of Privacy Practices

I hereby authorize treatment to the patient by the physician and/or staff of Medical & Surgical Eye Specialists. I also authorize release of any medical information necessary to process the insurance, and I authorize direct payment to Medical & Surgical Eye Specialists, Inc. I accept responsibility for payment of all charges incurred, as well as attorney and collection fees of 33 1/3% should such action become necessary. I agree to pay a \$25 fee if I fail to cancel a scheduled appointment within 24 hours. By my signature I also acknowledge that I have received a copy of and read the Medical & Surgical Eye Specialists' Summary Notice of Privacy Practices.

Signature	Date
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Review of Systems

Yes	No	Yes	No	Yes	No	Yes	No
General symptoms		Ears, nose, throat		Genitourinary		Psychiatric	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	Cardiovascular		Musculoskeletal		Endocrine	
Eyes		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	Respiratory		Integumentary		Hematological / Lymph	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	Gastrointestinal		Neurological		Allergic / Immunologic	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Past, Family and Social History (Please check all that apply)

	<u>You</u>	<u>Family</u>		<u>You</u>	<u>Family</u>
Cataracts	<input type="radio"/>	<input type="radio"/>	High blood pressure	<input type="radio"/>	<input type="radio"/>
Glaucoma	<input type="radio"/>	<input type="radio"/>	Diabetes	<input type="radio"/>	<input type="radio"/>
Crossed eyes	<input type="radio"/>	<input type="radio"/>	High cholesterol	<input type="radio"/>	<input type="radio"/>
Lazy eye	<input type="radio"/>	<input type="radio"/>	Heart attack	<input type="radio"/>	<input type="radio"/>
Macular degeneration	<input type="radio"/>	<input type="radio"/>	Stroke	<input type="radio"/>	<input type="radio"/>
Other eye disease	<input type="radio"/>	<input type="radio"/>	Congestive heart failure	<input type="radio"/>	<input type="radio"/>
Rheumatoid arthritis	<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>
Lupus	<input type="radio"/>	<input type="radio"/>	Emphysema	<input type="radio"/>	<input type="radio"/>
Sarcoidosis	<input type="radio"/>	<input type="radio"/>	Tobacco use	<input type="radio"/>	
Thyroid disorder	<input type="radio"/>	<input type="radio"/>	Drink alcohol	<input type="radio"/>	
Cancer or tumors	<input type="radio"/>	<input type="radio"/>	HIV/AIDS	<input type="radio"/>	

Reason for exam:

Please list any surgeries you have had:

Please list your current medications:

Please list any allergies to medication:

Who referred you to our office?

Who is your medical doctor?

Office Use Only

Reviewed _____ Date _____