

**HARVARD EYE ASSOCIATES OF ORANGE COUNTY
PATIENT INFORMATION SHEET**

Date: _____

MARITAL STATUS (Circle one): S M D W

SEX (Circle one): M F

NAME: _____ **BIRTH DATE:** _____

ADDRESS: _____ **AGE:** _____

_____ **SOCIAL SECURITY#:** _____

City _____ State _____ Zip _____

TELEPHONE #: (_____) _____ **DRIVER LICENSE#:** _____

EMPLOYER: _____ **EMERGENCY #:** (_____) _____

WORK #: (_____) _____ **CELL PHONE #:** (_____) _____

REFERRED BY: Post Card ____ T.V. Show ____ Health Fair ____ Other _____

OPTOMETRIST: _____ **FAMILY DOCTOR:** _____

Has another member of your family been seen in our office? _____ Name: _____

Nearest relative not living with you: _____ Phone #: _____

E-mail Address: _____

INSURANCE INFORMATION/PERSON RESPONSIBLE FOR ACCOUNT

1. PRIMARY INSURANCE: _____

NAME OF CARDHOLDER: _____

RELATIONSHIP TO PATIENT: _____

BIRTH DATE: _____ **SOCIAL SECURITY #:** _____

POLICY #: _____ **GROUP #:** _____

2. SECONDARY INSURANCE: _____

NAME OF CARDHOLDER: _____

RELATIONSHIP TO PATIENT: _____

BIRTH DATE: _____ **SOCIAL SECURITY #:** _____

POLICY #: _____ **GROUP #:** _____

VISION PLAN: _____ **POLICY #:** _____

NAME OF POLICY HOLDER: _____ **BIRTH DATE:** _____

****Please read and sign below****

AUTHORIZATIONS TO RELEASE MEDICAL RECORD INFORMATION AND ASSIGNMENT TO PAY PROVIDER DIRECTLY:

I hereby authorize payment directly to Harvard Eye Associates the insurance benefits to which I am entitled. I understand that I am financially responsible for charges not covered by my insurance. A photocopy of this authorization will be considered as valid as the original.

Patient Signature: _____

(Parent/Guardian, if minor)

I hereby authorize Harvard Eye Associates to provide information to insurance carrier and/or referring or family physician concerning my condition and treatments rendered. A photocopy of this authorization will be considered as valid as the original.

Patient Signature: _____

(Parent/Guardian, if minor)

MEDICAL HISTORY

NAME: _____ Male Female BIRTH DATE: _____

List current medical problems: _____

List previous surgeries: _____

List current medications: _____

Allergies to medications: No ___ Yes ___ Which ones? _____

SOCIAL HISTORY:

Do you drive? No ___ Yes ___ Do you smoke? No ___ Yes ___ Do you drink? No ___ Yes ___

How much? _____ How much? _____

ILLNESS (Past / Present) **(Please check where appropriate)**

Cardiac/Vascular (High Blood Pressure, Heart Disease, Cholesterol, Etc.) No ___ Yes ___ Psychiatric (Anxiety, Depression, Etc.) No ___ Yes ___

Endocrine/Glandular (Diabetes, Thyroid, Etc.) No ___ Yes ___ Blood/Lymph (Anemia, Cancer) No ___ Yes ___

Respiratory (Asthma, Respiratory, Etc) No ___ Yes ___ Neurological (Seizure, Neuropathy, Etc.) No ___ Yes ___

Genital/Kidney/Bladder/Stomach No ___ Yes ___ Autoimmune (Sjogrens, Lupus) No ___ Yes ___

Muscles/Bones/Joints (Arthritis, Etc.) No ___ Yes ___ General Health (Weight Loss, Fatigue, Allergy, Etc.) No ___ Yes ___

Gastrointestinal (Ulcer, Hernia, Colitis, Etc.) No ___ Yes ___ Physical Disabilities (Wheel chair/Cane/Walker) No ___ Yes ___

Ears/Nose/Throat (Sinus, Hearing) No ___ Yes ___ Cancer _____ No ___ Yes ___

EYE HISTORY (Have you recently experienced any of the following symptoms?)

Please circle where appropriate

Loss of vision Decrease in vision Blurred or Double vision Floaters or Flashes

Mucous Discharge Redness Irritation or Dryness Excessive tearing

Glare/Light sensitivity Eye pain Crossed/Lazy eyes Drooping eyelids

FAMILY HISTORY:

Please circle where appropriate

High blood pressure Diabetes Cancer Other _____

FAMILY HISTORY OF EYE DISEASE:

Please circle where appropriate

Glaucoma Retinal detachment Macular degeneration Color blindness Other _____

CONTACT LENSES/GLASSES

Do you wear glasses? No ___ Yes ___ If "YES", how old are your glasses? _____

Do you currently wear contact lenses? No ___ Yes ___ If "YES", how long have you been wearing them? _____

Have you ever tried contact lenses? No ___ Yes ___

Patient Signature Date