



PATIENT INFORMATION

Name _____ Birthdate _____ Age _____
Address _____ City _____ State _____ Zip _____
Phone (H) _____ (C) _____ Social Security # _____
E-mail address _____
Employer/ Occupation _____ Phone (W) _____
Sex: Male Female Hobbies _____ Do you live alone? Yes No
 Single Married Widowed Divorced Do you operate a motor vehicle? Yes No
Do you Smoke? Yes No (If yes, how much _____)
Spouse's Name _____ Phone _____

IN CASE OF EMERGENCY, CONTACT PERSON

Name _____ Relationship _____
Phone (H) _____ (W) _____ (C) _____

EYE HEALTH HISTORY

What is the reason for your visit today? _____
How did you hear about us? _____
Eye Doctor's Name _____ Date of last eye exam _____
Do you wear glasses or contacts? _____ How old is the prescription? _____
Type of contacts? Soft Hard How long have you been wearing glasses/contacts? _____
Are you using any eye drops of any kind (over-the-counter or prescription)? (please list)

Have you ever been treated by an Optometrist or Ophthalmologist for any eye disorders, injuries, or surgeries? (please list) _____

(Other Side)

If you are here for Refractive surgery, how have you learned about Refractive Lens exchange or LASER vision correction? Eye Doctor Patient who has had procedure Internet Previous Consult Not familiar with procedure Other: _____

MEDICAL HEALTH HISTORY

Primary Care Physician _____ Date of last exam _____

Are you using any medications or vitamins of any kind(over-the-counter or prescription)? (please list)

Are you currently being treated for any medical conditions? (please list)

Are you allergic to any medications or latex? (please list) _____

Do YOU or ANY of your Blood relatives have any of the following conditions?

(If so, please specify who and date of occurrence or onset)

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- | | |
|--|--|
| <input type="checkbox"/> Cataracts _____ | <input type="checkbox"/> Migraines/Headaches _____ |
| <input type="checkbox"/> Glaucoma _____ | <input type="checkbox"/> Auto Immune _____ |
| <input type="checkbox"/> Macular Degeneration _____ | <input type="checkbox"/> Herpes Simplex _____ |
| <input type="checkbox"/> Retinal Detachment _____ | <input type="checkbox"/> HIV _____ |
| <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Heart Dis./ Irreg. Heart Beat _____ | <input type="checkbox"/> Other _____ |
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RELEASE OF INFORMATION

I assign all medical/surgical benefits to Robbins Eye Associates for services performed by Robbins Eye Associates staff and authorize the release of information concerning my care to the health insurance agency.

I understand and agree that, regardless of insurance status, I am ultimately responsible for the balances of my account for any professional services rendered. Furthermore, I understand that if my account is turned over for collection, I will be responsible for all fees and expenses incurred by any collection agency or attorney.

SIGNED _____ DATE _____

(Patient/ Guardian/ Responsible individual – must be 18 years or older to sign)