Welcome to Our Office

In Order to serve you better, Please complete the following information *(Please Print)*:

Today's Date: _____

Patient's Name: _____ Date of Birth:_____

Social Security #:_____ Male or Female Married____ Single___ Other___

Address: _____

City, State, Zip: _____

Telephone #:_____Cell Phone # _____

Work # :_____ Email:_____

Occupation: _____ Employer: _____

Parent or Guardian Name: _____

Insurance Information

Insurance Name: _____ Group #:_____

Insured Name: _____ Date of Birth:_____

Relationship to Patient_____ Employer: _____

I.D. or S.S. # :_____

HIPPA Acknowledgment Form

Our HIPPA Regulations Packet provides information about how we may (or may not) use or disclose Protected Health Information (PHI) to protect you. It applies to the information and records we have about your health, health status, and the health care services you receive at this office. By signing this form, you are acknowledging that you can receive a copy here (if requested), or have received a copy, and understand the HIPPA regulations. I authorize the release of any medical information necessary to provide the most beneficial and complete visual examination. I authorize payment of medical benefits and services to Friendswood Eye Center. I understand that I am financially responsible for all charges whether or not paid by insurance. **Payment is due at the time services are rendered**.

Signature of Patient or Guardian_____

Medical History Record

In order to serve you better, please complete the following information: (PLEASE PRINT)

Today Date: _____

Patient's Name: _____ Date of Birth_____

Referred By:_____

Family Physician:_____ Doctor Phone #: _____

Date of last Eye Exam: _____ Name of Previous Eye Doctor: _____

Reason for today's visit: _____

_____

Personal Medical Information: Do you have any of these?

☐ Gastrointestinal ☐ Nervous System ☐ Mental ☐ Diabetes ☐ Headaches ☐ Ear/Nose, Throat
☐ Genitourinary ☐ Endocrine ☐ High Blood Pressure ☐ Skin ☐ Cardiovascular
☐ Musculoskeletal ☐ Blood/Lymph ☐Respiratory ☐ Surgeries (what type & when) _____

_____

Are you in good health? Yes ☐ No ☐
Are you allergic to any medications? Yes☐ No ☐ If yes please list_____

_____

Please Check Yes or No

Do you smoke? Yes☐ No ☐ How much? _____
Do you drink alcohol Yes☐ No ☐ How much? _____
Do you use other substances? Yes☐ No ☐
Do you take medications Yes ☐ No ☐ Please list name & how often_____

_____

Do you have Family History of any of following? (Mother, Father, Grandparents, Aunts, Uncles)

☐ Diabetes ☐ Glaucoma ☐ High Blood Pressure ☐ Macular Degeneration
☐ Retinal Detachment ☐ Cataracts

Do you have any of following?

☐ Dry Eyes ☐ Eye Surgeries ☐ Blurred Vision ☐ Eye Injuries ☐ Floaters
☐ Tearing/Itching Burning ☐ Lazy Eye ☐ Eye Infection / Sty's ☐ Double Vision ☐ Flashes

Any eye problems at this time?_____
Do you wear Glasses? Yes ☐ No ☐ Contact Lenses? Yes ☐ No ☐ Type/Brand_____
Number of hours you wear your contacts a day? _____
How often do you sleep in your contacts? (days/weeks/month) _____
What contact solution do you use? _____
Are you interested in Lasik Surgery? Yes☐ No☐

Please sign below that you have reviewed all information above and it is correct to the best of your knowledge.

Signature_____ Date_____