1

Patient's name, address, ...

Name _____, _____ __ (last name / first name) Birthdate: _____ Sex: M F

Address _____ Social Security #_____

_____ Tele *(home)* _____

_____, ___ _____ Tele *(day)* _____

Email _____ Tele *(cell)* _____

2

My marital status is:

- ❑ Single
- ❑ Married
- ❑ Divorced
- ❑ Widow/widower
- ❑ Separated
- ❑ Other _____

3

My Family Physician (PCP) is: _____

address _____

_____

_____, ___ _____

telephone # _____

4

Please address me as:

- ❑ Mr
- ❑ Mrs
- ❑ Miss
- ❑ Ms
- ❑ Dr
- ❑ Father
- ❑ Rev
- ❑ Sister
- ❑ Other _____

5

My occupation is: _____

My employer is: _____

My spouse's name is: _____

My emergency contact is: _____

relationship _____

telephone _____

I was referred to **South Jersey Eye Physicians** by: _____

6

Please indicate if this visit is either Workman's Comp or Motor Vehicle Accident related:

- ❑ Worker's Comp
- ❑ Motor Vehicle Accident

7

I authorize release of any medical information concerning today's treatment to my insurance company, attorney or other doctor's office. I also authorize direct payment to South Jersey Eye Physicians, P.A. I understand that, as these services are provided for me or my legal dependent, I am financially responsible for all charges, whether or not paid by insurance.

_____ _____

(date) (your signature)

Please sign here

8

page 2 OVER

Please help us by recording your insurance information here. Thank you.

INSURANCE #1: Company: _____ ID #: _____

Address---> PLAN: _____

information is required to file insurance claims

This insurance is ...

(please check one)

- ... in your name (you are male)
- ... in your name (you are female)
- ... in your wife's name
- ... in your husband's name
- ... in parent's name (boy child)
- ... in parent's name (girl child)

Subscriber information:

The "subscriber" for this policy (i.e. "name of insured") is: _____

Sex: ___

Birthdate: _____

Soc Security # _____

The subscriber's employer is: _____

information above is for the subscriber

INSURANCE #2: Company: _____ ID #: _____

Address---> PLAN: _____

information is required to file insurance claims

This insurance is ...

(please check one)

- ... in your name (you are male)
- ... in your name (you are female)
- ... in your wife's name
- ... in your husband's name
- ... in parent's name (boy child)
- ... in parent's name (girl child)

Subscriber information:

The "subscriber" for this policy (i.e. "name of insured") is: _____

Sex: ___

Birthdate: _____

Soc Security # _____

The subscriber's employer is: _____

information above is for the subscriber

Authorization to Disclose Medical Information

Patient Name: _____ Chart#: _____

Birthdate: _____ Date: _____

Address: _____

Permission to Disclose Medical Information *(Must be completed by a parent/guardian if the patient is under the age of 18)*

I give permission for South Jersey Eye Physicians, PA to discuss medical information for the above named patient, including examinations and test results with the following friends or family members. If left blank, information will only be given directly to the patient (or parent/guardian if under age 18).

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

This authorization will remain in effect at South Jersey Eye Physicians, PA until it is either revoked or changed.

This document is authorized and signed by ☐ self (patient) ☐ parent ☐ guardian

_____ _____
Signature Printed Name

Please answer these questions about your medical history:

Patient Name _____ Chart # _____ Date: _____

In order to take best care of your eyes, it is very important for us to understand your overall medical history and current condition. Please help us by fully and accurately answering the following questions while you wait to be called back to the clinic. If you don't know how to answer some of these questions, please do as much as you can, and ask the Technician for help on the rest after he/she begins your examination.

Please fill out all 3 sheets.

- - - - - - - -

Please check "yes" or "no" for each question.

Your personal medical history. Do you have any of the following?

Yes	No	Question	Explain
❑	❑	High Blood Pressure	
❑	❑	Diabetes (when was it diagnosed?)	
❑	❑	Vascular Disease	
❑	❑	Arthritis	
❑	❑	Heart Disease	
❑	❑	Lung Problems	
❑	❑	Stomach/intestinal problems	
❑	❑	Genital/Urinary Problems	
❑	❑	Thyroid	
❑	❑	Migraines	
❑	❑	Stroke, neurological disease	
❑	❑	Surgeries	
❑	❑	Other Problems	

Your Personal Eye History: Do you have any of the following EYE problems?

Yes	No	Question	Explain
❑	❑	Macular degeneration	
❑	❑	Cataracts	
❑	❑	Glaucoma	
❑	❑	Lazy Eye	
❑	❑	Eye Injury	
❑	❑	Surgery (what, when, which eye?)	

Your Family Medical History: To your knowledge, have any of your grandparents, parents, aunt or uncles, brothers or sisters ever had any of the following problems?

Yes	No	Question	Explain
❑	❑	Glaucoma	
❑	❑	Cataracts	
❑	❑	Diabetes	
❑	❑	Lazy Eye	
❑	❑	Macular Degeneration	
❑	❑	Other Ocular Problems	

. . . please continue with Page 2

Your Social History: Do you?

Yes	No	Question	Comments
❑	❑	Use Tobacco	
❑	❑	Drink Alcohol	
❑	❑	Drive	
❑	❑	Live Alone	
		What is your occupation (job)?	

Your PCP (primay care physician) **or pediatrician:** _____

Please provide: City _____

Telephone _____

drops, ointments & pills **for the EYE**

Medications you take for your eyes (Include over-the-counter drugs and vitamins/nutritional supplements):

Medication	Strength	Right Eye	Left Eye	Both Eyes	How often
_____	_____	R	L	Both	_____ times per day
_____	_____	R	L	Both	_____ times per day
_____	_____	R	L	Both	_____ times per day
_____	_____	R	L	Both	_____ times per day
_____	_____	by mouth			_____ times per day
_____	_____	by mouth			_____ times per day

medicines **NOT** for the EYE

Medications that you take for other problems (Include over-the-counter drugs and vitamins/nutritional supplements):

Medication	Strength	
_____	_____ dose	_____ times per day
_____	_____ dose	_____ times per day
_____	_____ dose	_____ times per day
_____	_____ dose	_____ times per day
_____	_____ dose	_____ times per day
_____	_____ dose	_____ times per day
_____	_____ dose	_____ times per day

Please list all medication allergies:

_____ _____

_____ _____

. . . please continue with Page 3

Please answer these questions about any symptoms / problems you may be experiencing:

	Yes	No	Question	Explanation
(const)	❑	❑	Have you gained/lost weight recently?	
	❑	❑	Do you feel tired all of the time?	
	❑	❑	Do you have headaches?	
(heent)	❑	❑	Do you have a persistent sore throat, sinus problems?	
	❑	❑	Do you have persistent earaches or hearing loss?	
(gi)	❑	❑	Do you have nausea, vomiting, abdominal pain or diarrhea?	
(gu)	❑	❑	Do you have any problems with urination, blood in your urine, or kidney problems?	
(cv)	❑	❑	Do you have chest pains or irregular heartbeat?	
(derm)	❑	❑	Do you have any skin problems –rashes, eczema, psoriasis, excessive dryness, etc?	
(resp)	❑	❑	Do you have problems with your lungs, chronic cough, difficulty breathing or wheezing?	
(ms)	❑	❑	Do you have problems with your bones, muscles or joints?	
(neuro)	❑	❑	Do you have convulsions or seizures?	
	❑	❑	Do you have confusion, numbness, weakness or paralysis?	

Please sign here. Thank you.

The above information is true and correct to the best of my belief.

_____ _____

(patient's signature) (date)

_____

(please sign here if parent or legal guardian)

_____ _____

(doc init) *(date)*

. . . please sign above