PENNWOOD OPHTHALMIC ASSOCIATES, PC

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NEW PATIENT INFORMATION

LAST: ________________________________FIRST:_____________________ M.I.: _________

ADDRESS: ____

CITY: ____ STATE: _________ ZIP: _____________

HOME PHONE: ____

WK PHONE: __________________________CELL PHONE: _____________________________

SEX: _______BIRTHDATE:___________________SSN:_________________________________

RACE: (circle one) WHITE BLACK/AFRICAN AMERICAN HISPANIC OTHER ___________

MARTIAL STATUS: ________ SPOUSE'S NAME: ______________________________________

SPOUSE'S BIRTHDATE: ____________________SSN: _________________________________

NAME OF PHARMACY: ___________________________PHONE#:_______________________

HOW DID YOU HEAR ABOUT OUR OFFICE? ____

FAMILY DOCTOR: ______________________ REFERRING DOCTOR: ____________________

**************************MUST BE COMPLETED BELOW **************************

POLICYHOLDER'S NAME: _________________________ DATE OF BIRTH: _________________

POLICYHOLDER'S SSN: _____________________ EMPLOYER: __________________________

" I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO PENNWOOD OPHTHALMIC ASSOICATES, PC FOR ANY SERVICES FURNISHED ME BY THE ABOVE DOCTORS. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE INSURANCE COMPANY AND ITS AGENTS AND INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES."

PATIENT'S SIGNATURE: __________________________________ DATE: ________________

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING EYE PROBLEMS RECENTLY:

	YES	NO
FLOATERS OR SPOT	_____	_____
FLASHING LIGHTS	_____	_____
JAGGED LINES	_____	_____
BLURRY NEAR VISION	_____	_____
BLURRY DISTANCE VISION	_____	_____
SUDDEN LOSS OF VISION	_____	_____
HALOS AROUND LIGHTS	_____	_____
PROBLEMS WITH GLARE	_____	_____
POOR SIDE VISION	_____	_____
FAINTING/DIZZINESS	_____	_____
SENSITIVITY TO LIGHT	_____	_____
ITCHING	_____	_____

	YES	NO
HEADACHES	_____	_____
EYE STRAIN	_____	_____
DOUBLE VISION	_____	_____
BLIND SPOTS	_____	_____
BURNING	_____	_____
MATTING/CRUSTING	_____	_____
TEARING	_____	_____
REDNESS	_____	_____
DRYNESS	_____	_____
GRITTY FEELING	_____	_____
SEASONAL ALLERGIES	_____	_____

ANY FAMILY MEMBER WITH THE FOLLOWING HEALTH CONDITIONS:

	YES	NO
CATARACTS	_____	_____
GLAUCOMA	_____	_____
MACULAR DEGENERATION	_____	_____
BLINDNESS	_____	_____
LAZY EYE	_____	_____

	YES	NO
HEART DISEASE	_____	_____
DIABETES	_____	_____
CANCER	_____	_____
OTHER	_____	_____

SOCIAL HISTORY:

	YES	NO
DO YOU DRIVE? ………………………………………………………………………………	_____	_____
DO YOU WEAR GLASSES? ………………………………………………………………………	_____	_____
ARE YOU PREGNANT? ……………………………………………………………………………….	_____	_____
ARE YOU A FORMER OR CURRENT SMOKER? …………………………………………….	_____	_____
DO YOU DRINK MORE THAN 4 ALCOHOLIC DRINKS PER WEEK? …………………	_____	_____

WHAT IS YOUR OCCUPATION? ____

ARE YOU A PREVIOUS OR CURRENT CONTACT LENS WEARER? YES NO

WHAT KIND? ________________ NAME OF SOLUTION? __________________

ARE YOU INTERESTED IN CONTACTS? YES NO

ARE YOU HAVING ANY PROBLEMS WITH YOUR CURRENTS CONTACTS YES NO

PLEASE EXPLAIN: ____

DO YOU ……

	YES	NO
WORK ON A COMPUTER FOR LONG PERIODS OF TIME?	_____	_____
HAVE MORE THAN ONE PAIR OF GLASSES?	_____	_____
HAVE GLASSES THAT ARE UNCOMFORTABLE?	_____	_____
WANT INFORMATION ON THINNER/LIGHTER LENSES?	_____	_____
WEAR BIFOCALS?	_____	_____
SPEND TIME OUTDOOR?	_____	_____
HAVE PRESCRIPTION SUNGLASSES?	_____	_____
EXPERIENCE GLARE WITH NIGHT DRIVING?	_____	_____
PLAY THE PIANO OR ORGAN?	_____	_____

PARTICIPATE IN ANY SPORTS OR HOBBIES? IF SO WHAT ___________________________

YOUR EYE HISTORY – DO YOU HAVE OR HAVE YOU EVER HAD:

	YES	NO		YES	NO
GLAUCOMA	____	____	EYE INJURY	____	____
MACULAR DEGENERATION	____	____	EYE INFECTION	____	____
CATARACTS	____	____	EYE SURGERY	____	____
RETINAL DISORDER	____	____	EYE TUMOR	____	____
CORNEAL DISEASE	____	____	LAZY EYE	____	____

YOUR MEDICAL HISTORY – DO YOU OR HAVE YOU HAD ANY OF THE FOLLOWING:

	YES	NO		YES	NO
DIABETES	____	____	ARTHRITIS	____	____
HIGH BLOOD PRESSURE	____	____	CANCER	____	____
HEART DISEASE	____	____	KIDNEY DISEASE	____	____
LUNG DISEASE	____	____	THYROID DISEASE	____	____
ASTHMA	____	____	SEIZURE DISORDER	____	____
DEPRESSION	____	____	STROKE	____	____
BLEEDING PROBLEMS	____	____	ANXIETY	____	____
SKIN DISORDER/RASH	____	____	MIGRAINES	____	____
HIGH CHOLESTROL	____	____	HIV	____	____

PLEASE LIST ANY ADDITIONAL HEALTH PROBLEMS AND PAST SURGERIES:

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PLEASE LIST ANY ALLERGIES TO MEDICATIONS:

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PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING INCLUDE DOSAGES AND HOW OFTEN THE MEDICATION IS TAKEN. PLEASE INCLUDE ANY EYE DROPS AND/OR OVER THE COUNTER MEDICATIONS (ASPIRIN, MULTI VITAMINS, ETC) OR ATTACH YOUR OWN LIST

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