Patient Information Sheet

Today's Date _____ **Date of Birth** _____ **Age** _____ **Sex**: Male □ Female □
MM/DD/YYYY MM/DD/YYYY If female, are you pregnant or nursing? Yes No

Patient Name: _____ **Social Security #** _____
(First, Middle, Last Name)

Street Address: _____ **Apt #** _____

City _____ **State** _____ **Zip Code** _____-_____

Email: Home _____ Work _____

Telephone: Home ( ) _____- _____ Work ( ) _____- _____ Ext. _____ Mobile/Cell ( ) _____-_____

Employment Status: Employed-Part-Time □ Full-Time □ Not Employed □ Retired □ Disabled □ Student □ Military □
Patient's **Marital Status**: Single □ Married □ Divorced □ Separated □ Widowed □ Domestic Partner □ Other □

Spouse/Partner Name _____ **Responsible Party** (if minor) _____-_____
Date of Birth _____ Date of Birth _____ (First, Middle, Last Name)

REVIEW OF GENERAL HEALTH

Date of Last Eye Exam ___/___/____ Doctor _____ Any problems? Yes No

Date of Last Physical Exam ___/___/____ Doctor _____ Any problems? Yes No

Are you <u>currently</u> being treated for any acute illness (cold, fever, infection)? **Yes No** *If yes, describe* _____

Current Medications (prescription and over the counter) _____

Do you have health problems in any of the following?

Heart/Circulation	Yes	No	Kidneys	Yes	No	Do you smoke? **Yes No**	
Breathing	Yes	No	High Blood Pressure	Yes	No	Do you use alcohol regularly? **Yes No**	
Stomach/Intestinal	Yes	No	Diabetes	Yes	No	Are you allergic to any Medications? **Yes No**	
Muscles/Bones	Yes	No	Ear, Nose, Throat	Yes	No	If yes, list:	
Skin	Yes	No	Thyroid	Yes	No		
Neurological	Yes	No	Urinary Tract	Yes	No		
Psychiatric	Yes	No	High Cholesterol	Yes	No		

Does anyone in your family have a history of:

			Relationship to you				Relationship to you
Glaucoma	Yes	No		Macular Degeneration	Yes	No	
Retinal Detachment	Yes	No		Diabetes	Yes	No	

Have you ever had an eye injury? Yes No If yes, describe _____
Do you have problems with headaches? Yes No If yes, frequency _____

<u>INSURANCE INFORMATION</u> Please present your insurance information at the time of your appointment.

Vision Plan _____ ID # _____ Insured's Name _____ Date of Birth _____

Primary **Health** Insurance _____ ID # _____

Insured's Name/Signature _____ Date of Birth _____ Relationship _____
Are you or any other member of your family covered by another medical or vision policy? MM/DD/YY

Other **Health** Insurance _____ ID # _____

Insured's Name/Signature _____ Date of Birth _____ Relationship _____
MM/DD/YY

I request that payment of aurthorized Medicare benefits or any isurance benefits be made either to me or on my behalf to Dr. Mark S. Newman, OD for any services rendered me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration or any insurance company and its agents or other medical entities any information needed to determine these benefits or benefits payable for related services.

Patient/Parent/Guardian Signature _____ Date _____

Who may we thank for referring you? _____