DATE:_____/_____/_____ **Referred by**:_____

_____ _____ _____ **DOB** _____/_____/_____
(Last Name) (First Name) (M.) (MM) (DD) (YY)

HOME ADDRESS:_____ APT #_____

CITY_____ STATE_____ ZIP_____ PHONE: _____-_____

S.S#_____-_____-_____ EMAIL:_____

INSURANCE:_____ INSURANCE ID#_____ GROUP #_____

EMPLOYER/PARENT:_____ ADDRESS:_____BUS. PH:_____

OCCUPATION:_____ EMERG. CONTACT_____ PHONE_____

(PAYMENT IS DUE AT THE TIME OF SERVICES UNLESS ANOTHER ARRANGEMENT IS MADE IN ADVANCE.)

DRUG ALLERGIES: _____
MEDICATIONS: _____
OPERATIONS: _____
SERIOUS ILLNESSES :_____
FAMILY HISTORY (diseases in your family like retinal detachment, glaucoma?) _____
GENERAL DOCTOR:_____ **Address** _____ **Phone** _____
PRESENT EYE COMPLAINTS or PROBLEMS_____
_____

LAST EYE EXAM (Dr. + DATE): _____

Review of Systems and Social History - Circle "OK" if OK or indicate the problem:

Eyes - past problems: OK or _____
Constitutional (fever, weakness): OK or _____
Heart, blood pressure, circulation: OK or _____
Gastrointestinal and Liver: OK or _____
Ear, nose, throat: OK or _____
Lungs: OK or _____
Genital-urinary trouble: OK or _____
Neurologic disorder: OK or _____
Muscles, bones, joints: OK or _____
Skin: OK or _____
Blood - lymphatic: OK or _____
Psychiatric: OK or _____
Other: _____
Drive: Y or N (circle) Smoking: _____ Alcohol (amount and frequency): _____

>>> TURN AND COMPLETE BACK OF FORM. >>>

Privacy Notification & Authorization

I authorize the routine release of my medical information for purposes of treatment, billing, and routine health care operations such as quality assurance monitoring. I understand that my medical information will not be released for any other purposes without my consent.

Signature:_____ **Date**:_____

Patients have the right to file a complaint with Eye Surgeon PC or with the Department of Health and Human Services. If you wish to review the privacy policies of Eye Surgeon PC in more detail, a copy is available from your doctor.

Insurance or Medicare Authorization

I request that payment of authorized health care benefits be made to Dr. Charles A. Cole and/or Dr. Jane A. Lee for services furnished to me by them. I authorize any medical information about me be released to the my health care insurance companies or the Health Care Finance Administration and its agents and any information needed to determine these benefits or the benefits payable for related services.

Signature:_____ **Date**:_____