PATIENT PROFILE

Patient Name: _____
Address: _____
City/State/Zip: _____
Most Reliable Phone Number: _____
Email address: _____
Sex: ☐male ☐female
Birthdate: ____ / ____ / ____
Social Security Number: _____
Occupation: _____
Employer: _____
Employer Phone Number: _____
Hobbies: _____
How did you hear about us? _____
Race:

☐ African American ☐ Asian ☐ Caucasian
☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander

Ethnicity:

☐ Hispanic or Latino ☐ Not Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander

Primary Care Physician: _____
City, State: _____
Marital Status: ☐married ☐single ☐widowed
Spouse's Name: _____
If **child**, please provide Mother and Father's name:
_____/_____

Person Responsible for Bill (Guarantor):

☐same as patient ☐parent of patient ☐spouse ☐other
Name: _____
Address: _____
City/State/Zip: _____
Most Reliable Phone Number: _____
Email address: _____
Sex: ☐male ☐female
Birthdate: ____ / ____ / ____
Social Security Number: _____
Occupation: _____
Employer: _____
Employer Phone Number: _____
Relation to patient: _____

Emergency Contact:

Name: _____
Relation: _____
Phone Number(s): _____

PATIENT MEDICAL & OCULAR HISTORY

Medications: _____
_____
_____
_____
_____
_____
_____
_____
Allergies: _____
_____
_____

Patient Ocular & Medical Conditions:
(check all that apply):

☐ Glaucoma	☐ Crossed eyes	☐ Cataracts
☐ Diabetes	☐ Hypertension	☐ Stroke
☐ High cholesterol	☐ Heart attack	☐ Heart failure
☐ Thyroid disorder	☐ Peptic ulcers	☐ Lupus
☐ Sjogren's	☐ Anemia	☐ Leukemia
☐ Herpes Zoster	☐ Hepatitis	☐ HIV/AIDS
☐ Psoriasis	☐ Arthritis	☐ Migraines
☐ Multiple sclerosis	☐ Seizures	☐ Anxiety
☐ Depression	☐ Asthma	☐ Tuberculosis
☐ Sleep apnea	☐ Pregnant	☐ Nursing

☐ Other(s): _____
_____
_____
_____

Patient Social History: *(required by Medicare)*

☐ Never Smoked
☐ Former Smoker: quit smoking _____ years ago
☐ Current Smoker:
____ packs/day; ____ years smoking
☐ Current Smokeless Tobacco User
☐ Alcohol Usage: _____

Patient's Family History:

**Please note which family member using:*
M=Mother, F=Father, S=Sibling, G=Grandparent

☐ Blindness ____	☐ High Blood Pressure____
☐ Glaucoma ____	☐ Retinal Disease ____
☐ Diabetes ____	☐ Crossed Eyes ____
☐ Cancer ____	☐ Macular Degeneration____