The Eye Center

OF SOUTHERN INDIANA

ABOUT YOU

Name ____ **Date of Birth** _________________

Is this your legal name? ☐ YES ☐ NO Legal name:____

Address____
Street Address City State Zip Code

Gender Assigned at Birth: ☐Male ☐ Female

Home phone (______)_____________**Cell phone** (_____)____________ **Soc. Security #**________________

Email address ____________________________ **Pharmacy**____________________________

Are you employed? (Circle one)

Full-time	Part-time	Self-employed	Retired	Military Duty	Not Employed

Employer____

Employer's address _______________________________________ **Work phone** (_____)______________

Are you a student? ☐ YES ☐ NO (circle one) Full time or Part time

Marital Status (Circle one)

Single	Married	Widowed	Separated	Divorced	Partner	Other

Please list an emergency contact (someone NOT living with you)

Name____

Relationship_________________________ Phone (____) _______________________________

Primary Care Physician ______________________________ **Location:** _________________________
First name Last name

Referring Doctor_______________________

Are you a resident of a Temporary Skilled Nursing Facility? ☐ YES ☐ NO

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Please see other side

INSURANCE

Major Medical Insurance ____

(We do not file vision insurance because we are a medical practice.)

Are you the policy holder? ☐ YES ☐ NO **Policy #**______________ **Group #** ______________

If no, name of policy holder ______________________________ **Relationship**____________________

Policyholder's Date of Birth __________________ **Soc. Security #** _______________________

Address____ **Phone (____)**_____________________

Do you have a secondary insurance? ☐ YES ☐NO

Name of Secondary Insurance____

Are you the policy holder? ☐ YES ☐ NO **Policy #** ________________ **Group #** _______________

If no, name of policy holder _____________________________ **Relationship**____________________

Policyholder's Date of Birth ____________________ **Soc. Security #** ______________________

Address____ **Phone (_____)**_____________________

RESPONSIBLE PARTY

Please complete this section if the financially responsible party for this account is someone other than the patient, or if the patient is a minor.

Responsible Party __________________________________ **Phone (_____)**_____________________

Address____________________________ **City/State**______________________ **Zip**_______________

Gender: ☐ Male ☐ Female **Date of Birth** ________________________

Soc. Security # ______________________________ **Employer**________________________

Email ____

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MEDICAL HISTORY

Do you have any of the following eye problems? *Please check all that apply.*

☐ Cataracts ☐ Glaucoma ☐ Macular Degeneration ☐ Eye trauma

☐ Retinal tearing ☐ Retinal detachment ☐ Glaucoma Suspect ☐ Diabetic eye disease

☐ Other (please specify): ____________________

Have you had any of the following eye surgeries? *Please include the **date** and **which eye**.*

	Date	Date	Surgeon
Cataract	R ________	L ________	________
After cataract laser	R ________	L ________	________
Injections to the eye	R ________	L ________	________
Diabetic laser	R ________	L ________	________
Glaucoma laser	R ________	L ________	________
Lasik/PRK	R ________	L ________	________
Eyelid repair	R ________	L ________	________

Do you have any of the following medical conditions?

☐ AIDS ☐ Alzheimer's ☐ Arthritis ☐ Asthma ☐ Back problems ☐ Cancer

☐ COPD ☐ Diabetes type I ☐ Diabetes type II ☐ Dementia ☐ Heart disease

☐ High Blood Pressure ☐ High cholesterol ☐ HIV ☐ Kidney disease ☐ Osteoporosis

☐ Other (please specify): ____________________

Have you had any of the following surgeries?

☐ Appendix ☐ Tonsillectomy ☐ Carpal Tunnel ☐ Gallbladder ☐ Colonoscopy

☐ Heart Bypass ☐ Pacemaker ☐ Heart stent ☐ Heart valve ☐ Prostate

☐ Knee replacement ☐ Knee repair ☐ Hip replacement ☐ Hysterectomy

☐ Mastectomy ☐ Biopsies ____________________

☐ Other (please specify): ____________________

____

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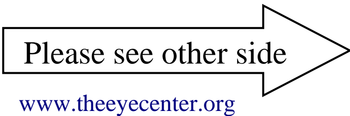

FAMILY HISTORY

Does your __Family__ have a history of any of the following

	Mother	Father	Sibling	Child	Grandparent
Cataract					
Glaucoma					
Macular Degeneration					
Retinal Detachment					
Blindness					
Diabetes					
High Blood Pressure					
Heart Disease					
Cancer					

ALLERGIES

Do you have any DRUG ALLERGIES? ☐ **YES** ☐ **NO**

__Please list all medications you are allergic to.__

Allergies:

Medication ________________ Reaction ________ Severity________
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Medication ________________ Reaction ________ Severity________
Medication ________________ Reaction ________ Severity________

__Are you allergic to__:

Latex ☐ YES ☐ NO Reaction ________________
Iodine ☐ YES ☐ NO Reaction ________________
Shellfish ☐ YES ☐ NO Reaction ________________

LIFESTYLE

Do you drink alcohol? ☐ Never ☐ Rarely ☐ Socially ☐ Moderately ☐ Heavy

Smoking Status:
☐ Never ☐ Current ☐ Former

Do you drive an automobile? ☐ YES ☐ NO

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Name: ____ Date of birth: ____________________

MEDICATION LIST

Please list all medications you are currently taking.
Include over-the-counter medicines, vitamins and supplements.

Drug Name	Mg/dose	Purpose

Are you currently taking any of the following? ***Please check all that apply.***

☐ **Aspirin 81mg** ☐ **Aspirin Other** ☐ **Flomax** ☐ **Tamsulosin** ☐ **Plavix**

Please let our staff know if you require any special accommodations.
We look forward to caring for you!

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