



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

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 _____

R. Daniel Grossman, M.D.

Chad E. Huck, O.D.

Steven E. Holbrook, O.D.

Warren J. Chang, M.D.

Joseph M. Mackey, M.D.

Jason P. Gray, O.D.

Frank N. Hrisomalos, M.D.

Andrew H. Huck, M.D.

1011 West Second Street

Bloomington, Indiana 47403

(812) 334-1213

FAX (812) 333-5039

www.theeyecenter.org

Please see other side

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.*

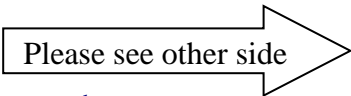
	Date	Date	Surgeon
Cataract	R _____	L _____	_____
After cataract laser	R _____	L _____	_____
Injections to the eye	R _____	L _____	_____
Diabetic laser	R _____	L _____	_____
Glaucoma laser	R _____	L _____	_____
Lasik/PRK	R _____	L _____	_____
Eyelid repair	R _____	L _____	_____

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): _____



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 _____
Medication _____	Reaction _____	Severity _____
Medication _____	Reaction _____	Severity _____
Medication _____	Reaction _____	Severity _____

Are you allergic to:

Latex	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Reaction _____
Iodine	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Reaction _____
Shellfish	<input type="checkbox"/> YES	<input type="checkbox"/> 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!*