

Mid-State Eye Intake Form

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1. Patient Information:

Title: <input type="radio"/> Dr. <input type="radio"/> Mr. <input type="radio"/> Mrs. <input type="radio"/> Ms.	Last Name: _____	First Name: _____	Middle Initial: _____
Preferred Name: _____	Date of Birth: _____	Gender: <input type="radio"/> Male <input type="radio"/> Female	
Address: _____		Apt./Unit #: _____	
Social Security #: _____	Marital Status: <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Widowed		
Home Phone: _____	May we leave a message on your phone? <input type="radio"/> Yes <input type="radio"/> No		
Cell Phone: _____	May we leave a message on your phone? <input type="radio"/> Yes <input type="radio"/> No		
Daytime Phone: _____	May we leave a message on your phone? <input type="radio"/> Yes <input type="radio"/> No		
Email Address: _____	May we contact you via email? <input type="radio"/> Yes <input type="radio"/> No		

2. Emergency Contact:

Name: _____	Phone: _____
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3. If patient is a minor:

Guardian Name: _____	Relationship: _____	Phone: _____
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4. Insurance Information:

Primary Insurance: _____	ID #: _____	
Insured's Name: _____	Date of Birth: _____	SSN #: _____
Relationship to insured: <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Dependent	Employer's Name: _____	

5. Secondary Insurance:

ID #:

Insured's Name:

Date of Birth:

SSN #:

Relationship to insured:

Self Spouse Dependent

Family History Information

6. Have any of your blood relatives, living or deceased, had any of the following conditions.

	YES	NO
Glaucoma		
Cataract		
Crossed Eyes		
Macular Degeneration		
Retinal Disease/Detach		
Blindness		
Cancer		
Diabetes		
High Blood Pressure		
Heart Disease		
Kidney Disease		

Referral

7. How did you hear about us?

- Insurance list Sign/Marketing Phonebook
 Website Friend/Family

If Friend/Family, please specify:

Personal Medical/Ocular History Form

8. What is the name of your primary care physician?

Medical History

9. Have you ever been diagnosed with any of the following:

	YES	NO
Diabetes		
High Blood Pressure		
Heart Disease		
High Cholesterol		
Kidney/Liver Disease		
Hypo/Hyperthyroidism		
Cancer		
Stroke		

10. Do you take any medications on a regular basis?

- Yes
- No

11. If yes, please list:

	Medication Name	Dosage	Frequency	Reason for Taking
1				
2				
3				

12. Do you have allergies to medication?

- Yes
- No

13. If yes, please list:

	Medication Name	Reaction
1		
2		
3		

14. Do you smoke?

- Yes
- No

15. Do you drink alcohol?

- Yes
- No

16. Are you pregnant/nursing?

- Yes
- No

Ocular History

17. Who performed your last eye exam?

When:

18. Have you ever been diagnosed with any of the following:

	YES	NO
Glaucoma		
Cataracts		
Corneal Disease		
Macular Degeneration		
Retinal Disease/Detach		
Crossed Eyes		

19. Have you ever had surgery on your eyes?

- Yes
- No

20. If yes, please list:

21. Please list all eye medications:

22. What is the reason for your visit today?

	YES	NO
Distance vision blur		
Near vision blur		
New contact lenses		
New glasses		
Glaucoma		
Cataracts		
Red Eyes		
Painful Eyes		

23. How old are your current glasses?

24. If you wear contacts, what brand?

25. Are you satisfied with them?

- Yes
- No

26. Please list name of any specific individuals to whom we may release personal and medical/vision information:
