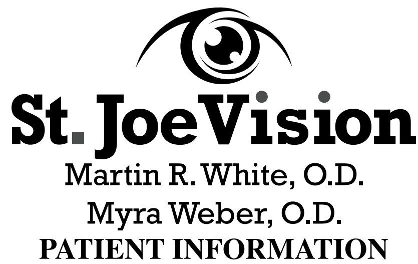

Martin R. White, O.D.
Myra Weber, O.D.

PATIENT INFORMATION

How did you hear about our office?______________________________

Reason for today's visit? ______________________________

Date of last exam?

PATIENT INFORMATION

Name______________________________

Is there another name you go by? "______________________"

Age ____________ Birthdate______________________

Street Address ______________________________

City ________________ State ________ Zip ________

Home phone ______________________________

Work phone ______________________________

Cell phone ______________________________

Email Address ______________________________

Place of employment ______________________________

Occupation ______________________________

Social Security # ______________________________

Marital status ______________________________

Family physician ______________________________

Health Insurance ______________________________

Method of payment

❏ Check ❏ Cash ❏ Credit Card ❏ Insurance

Would you like information on our Privacy Practices?

❏ Yes ❏ No

INSURANCE INFORMATION

Medical Insurance:______________________________

Vision Insurance: ______________________________

INSURANCE AGREEMENT

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE AND/OR MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO MARTIN R. WHITE, O.D. FOR ANY SERVICES RENDERED ME.

I FURTHER REQUEST THAT ANY SUPPLEMENTAL INSURANCE BENEFITS FILED ON MY BEHALF PAID AS STATED ABOVE. I AGREE THAT I AM RESPONSIBLE TO PAY ANY DEDUCTIBLES, CO-PAYMENTS OR CHARGES NOT COVERED BY MY INSURANCE OR SUPPLEMENTAL INSURANCE.

Patient signature: ______________________________ Date: ________________

OVER

MEDICAL HISTORY QUESTIONNAIRE

List any medications you are currently taking (prescription and over the counter):______________________________

____

Do you have allergies to any medications? ☐ Yes ☐ No If YES, list the medications:______________________________

____

ROS (Review of Systems)

Do you currently have any problems in the following areas? If "YES", provide information:

System	Y/N	Brief Explanation of Problem
CONSTITUTIONAL SYMPTOMS (fever, weight loss, etc.)		
EAR, NOSE, THROAT, MOUTH		
CARDIOVASCULAR (heart, hypertension, etc.)		
RESPIRATORY (asthma, emphysema, etc.)		
GASTROINTESTINAL		
GENITAL, KIDNEY, BLADDER		
MUSCLES, BONES, JOINTS (arthritis, etc.)		
SKIN (rash, itching, skin cancer, etc.)		
NEUROLOGICAL (multiple sclerosis, etc.)		
PSYCHIATRIC (anxiety, depression, etc.)		
ENDOCRINE (diabetic, hypothyroid, etc.)		
BLOOD/LYMPH (anemia, cholesterol, etc.)		
ALLERGIC/IMMUNOLOGIC (seasonal allergies, lupus, etc.)		
PREGNANT, NURSING		

PAST EYE HISTORY AND RELATED SYSTEMIC CONDITIONS

Have you EVER been diagnosed with the following conditions? If "YES" indicate when diagnosed and treated.

Condition	YES	NO	Date Diagnosed and description of treatment
AGE RELATED MACULAR DEGENERATION			
GLAUCOMA			
CATARACTS			
EYE INJURY			
EYE SURGERIES			
DIABETES			
HIGH BLOOD PRESSURE			
CANCER			
STROKE			
ARTHRITIS			

FAMILY HISTORY

M=mother F=father S=sibling GP=grandparent

Eye Diseases	Y/N	Relationship to patient	Systemic Diseases	Y/N	Relationship to patient
AMBLYOPIA (lazy eye)			**ARTHRITIS**		
BLINDNESS			**CANCER**		
CATARACT(S)			**DIABETES**		
COLOR BLINDNESS			**HEART DISEASE**		
EYE TUMORS			**HIGH BLOOD PRESSURE**		
GLAUCOMA			**KIDNEY DISEASE**		
GLAUCOMA SUSPECT			**LUPUS**		
MACULAR DEGENERATION			**STROKE**		
RETINAL DETACHMENT			**THYROID DISEASE**		
STRABISMUS (eye turn)			**OTHER EYE CONDITIONS**		

SOCIAL HISTORY

Do you drink alcohol? ☐ Yes ☐ No If yes – How many alcoholic drinks per day?____________________

Do you smoke? ☐ Yes ☐ No If yes – How many packs per day?_______ Past smoker? ☐ Yes ☐ No If yes – When did you quit?__________

Are you planning to get glasses today? ☐ Yes ☐ No ☐ Only if RX changes

Do you currently wear contact lenses? ☐ Yes ☐ No Are you interested in wearing contact lenses? ☐ Yes ☐ No

If yes, what type: ☐ Soft ☐ Extended Wear ☐ Gas Permeable ☐ Bifocals ☐ Tinted ☐ Astigmatic ☐ Disposable ☐ Unsure