

MEDICAL HISTORY

FIRST NAME _____ M.I. _____ LAST NAME _____
ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
HOME PH _____ WORK PH _____ EXT _____
CELL PH _____ EMAIL _____
SS# _____ D.O.B. _____ AGE _____ SEX _____
EMERGENCY CONTACT _____ PHONE _____

Are you interested in learning more about decreasing your dependence on glasses/contacts?

YES NO

Which of the following referred you to Whitten Laser Eye: (Please be specific. List all sources.)

Friend/Relative/Patient Names _____	Newspaper _____ Mailing _____	Seminar _____
Physician _____	Internet/Website _____ Event _____	Other _____
_____	Article _____	_____

PRIMARY INSURANCE INFORMATION

PRIMARY INSURANCE _____
INSURED NAME _____ INSURED'S D.O.B. _____
POLICY NUMBER _____ GROUP NUMBER _____
CO-PAY AMOUNTS _____

SECONDARY INSURANCE INFORMATION

SECONDARY INSURANCE _____
INSURED NAME _____ INSURED'S D.O.B. _____
POLICY NUMBER _____ GROUP NUMBER _____

PATIENT AUTHORIZATION

I authorize Whitten Laser Eye to apply for benefits on my behalf for services rendered. I request payment from my insurance company to be made directly to the physician. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical service provided, when a statement is rendered. I understand I will be responsible for any collection fees if my account is delinquent and referred to an attorney for collection purposes. Attorney's fees of 15% will be charged in addition to principal balance of the account if referred to an attorney for collection purposes. Delinquent accounts accrue interest at the rate of 1 1/2% per month.

SIGNATURE _____ DATE _____

Patient Name _____
Primary Care Physician _____
When was your last eye exam? _____
By whom? _____

Occupation or hobby _____
Computer Use: Never Occasional Daily
Do you wear glasses? Yes No
Do you wear contact lenses? Yes No

PHARMACY NAME & ADDRESS _____

PAST MEDICAL HISTORY

1. Have you ever been treated for any medical condition? (e.g. diabetes, high blood pressure, heart attack, stroke) Yes No
If yes, explain: _____

2. Have you ever had any eye disease? (e.g. glaucoma, macular degeneration, eye turning in or out) Yes No
If yes, explain: _____

3. Have you ever had any surgeries? Yes No
If yes, explain: _____

4. Do you take any medications? (Please include any vitamins and aspirin.) Yes No
If yes, explain: _____

5. Medication Allergies: _____

REVIEW OF SYSTEMS

Do you currently have any problems with the following:

	YES	NO
Chronic fever, unexpected weight loss or gain, fatigue	<input type="radio"/> Yes	<input type="radio"/> No
Ear/nose/throat (e.g. hearing loss, sore throat, sinus)	<input type="radio"/> Yes	<input type="radio"/> No
Heart (e.g. chest pain, irregular heart beat)	<input type="radio"/> Yes	<input type="radio"/> No
Respiratory (e.g. shortness of breath, coughing)	<input type="radio"/> Yes	<input type="radio"/> No
Gastrointestinal (e.g. heartburn, diarrhea, vomiting, stomach pain)	<input type="radio"/> Yes	<input type="radio"/> No
Urinary (e.g. pain or discomfort, blood in urine)	<input type="radio"/> Yes	<input type="radio"/> No
Skin conditions (e.g. rash, excessive dryness)	<input type="radio"/> Yes	<input type="radio"/> No
Musculoskeletal (e.g. swollen joints, joint pain)	<input type="radio"/> Yes	<input type="radio"/> No
Neurological (e.g. numbness, weakness, headache, paralysis)	<input type="radio"/> Yes	<input type="radio"/> No
Psychiatric (e.g. depression, anxiety)	<input type="radio"/> Yes	<input type="radio"/> No
Endocrine (e.g. diabetes, thyroid)	<input type="radio"/> Yes	<input type="radio"/> No
Blood Lymph (e.g. high cholesterol, anemia)	<input type="radio"/> Yes	<input type="radio"/> No

FAMILY AND SOCIAL HISTORY

Do any eye or medical diseases run in your family? (e.g. diabetes, high blood pressure, cancer, glaucoma, macular degeneration)
 Yes No
If yes, explain: _____

Do you smoke? Yes No

Do you drink alcohol? Yes No

PLEASE CIRCLE REASON FOR YOUR VISIT TODAY:

Routine Surgery Glasses/Contact Lenses Medical Problem

Patient/Parent Signature: _____

Reviewed By: _____ Date: _____ No Changes Updated _____