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?

O YES O NO

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

Friend/Relative/Patient
Names_____
_____
Physician_____
_____

Newspaper_____
Mailing_____
Internet/Website_____
Event_____
Article_____

Seminar
_____
Other_____
_____
_____

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_____ Occupation or hobby_____
Primary Care Physician_____ Computer Use: O Never O Occasional O Daily
When was your last eye exam?_____ Do you wear glasses? O Yes O No
By whom? _____ Do you wear contact lenses? O Yes O 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) O Yes O No
If yes,explain: _____
_____

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

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

4. Do you take any medications? (Please include any vitamins and aspirin.) O Yes O 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	O Yes	O No
Ear/nose/throat (e.g. hearing loss, sore throat, sinus)	O Yes	O No
Heart (e.g. chest pain, irregular heart beat)	O Yes	O No
Respiratory (e.g. shortness of breath, coughing)	O Yes	O No
Gastrointestinal (e.g. heartburn, diarrhea, vomiting, stomach pain)	O Yes	O No
Urinary (e.g. pain or discomfort, blood in urine)	O Yes	O No
Skin conditions (e.g. rash, excessive dryness)	O Yes	O No
Musculoskeletal (e.g. swollen joints, join pain)	O Yes	O No
Neurological (e.g. numbness, weakness, headache, paralysis)	O Yes	O No
Psychiatric (e.g. depression, anxiety)	O Yes	O No
Endocrine (e.g. diabetes, thyroid)	O Yes	O No
Blood Lymph (e.g. high cholesterol, anemia)	O Yes	O 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)
O Yes O No
If yes,explain: _____
_____

Do you smoke? O Yes O No Do you drink alcohol? O Yes O No

PLEASE CIRCLE REASON FOR YOUR VISIT TODAY:

Routine Surgery Glasses/Contact Lenses Medical Problem

Patient/ParentSignature:_____

Reviewed By:_____ Date:_____ O No Changes O Updated_____