



Date: _____

First Name: _____ MI: _____ Last Name: _____

Preferred Name: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone: (____) _____ Wk. Phone: (____) _____ Cell: (____) _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____ Sex: Male Female

Marital Status: Married Single Widowed Divorced Other _____

Social Security #: _____ Retired Working Full-Time Working Part-Time

Race/Ethnicity: American Indian Asian or Pacific Islander Hispanic Non-Hispanic
 Black White Other Unknown

Employer: _____ Employer's Address: _____

City: _____ State: _____ Zip: _____

Insurance Information

Primary Insurance: _____ I.D.# _____ Group #: _____

Secondary Insurance: _____ I.D.# _____ Group #: _____

**Primary Insured/Responsible Party information
(if different from patient)**

First Name: _____ MI: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (____) _____ Wk. Phone (____) _____ Cell: (____) _____

Date of Birth: _____ Age: _____ Sex: Male Female

Marital Status: Married Single Widowed Divorced Other _____

Social Security # _____ Retired Working Full-Time Working Part-Time

Employer: _____ Employer's Address: _____

City: _____ State: _____ Zip: _____

Whom may we thank for referring you? Dr. _____

What doctor do you normally see for glasses? _____

Phone: (____) _____ Date of Last Eye Exam: _____

Do you wear glasses? Yes No (If yes, at what age did you first get glasses? _____)
(If yes, how old are your current glasses? _____)

Do you wear contacts? Yes No (If yes, please remove 3 days prior to evaluation (for soft) or 3 weeks prior for Gas Permeable (for hard).)

Eye Health

Please check any current eye problems or symptoms you may currently be experiencing:

<input type="checkbox"/> READING	<input type="checkbox"/> DRIVING	<input type="checkbox"/> DRY EYES	<input type="checkbox"/> EYE ITCH
<input type="checkbox"/> WATCHING TV	<input type="checkbox"/> STREET SIGNS	<input type="checkbox"/> WATERY EYES	<input type="checkbox"/> EYE BURN
<input type="checkbox"/> GLARE	<input type="checkbox"/> SUNLIGHT	<input type="checkbox"/> NIGHT DRIVING	<input type="checkbox"/> EYES FEEL SANDY
Other: _____			

Have you ever been told you have glaucoma? Yes No

Have you ever been told you have cataracts? Yes No (If yes, when?) _____

Have you ever had any type of eye surgery (i.e. Lasik)? Yes No (If yes, please explain) _____

Have you ever had an eye injury? Yes No (If yes, please explain) _____

Do you use eye drops? Yes No (If yes, what kind) _____

General Health

Please list all prescription medications you are currently taking:

Pharmacy _____ Location # _____

Please list any medications you are **ALLERGIC** to:

Do you take a blood thinner or Aspirin ? Yes No (If yes, which and what dose?) _____

Do you smoke? Yes No Do you drink? Yes No Do you exercise? Yes No

Please circle "Yes" or "No" to indicate if you have or have had any of the following:

Yes	No	Aids/HIV	Yes	No	Heart Condition - <i>If yes, what kind?</i> _____
Yes	No	Arthritis	Yes	No	Hepatitis - <i>If yes, what type?</i> _____
Yes	No	Asthma/COPD	Yes	No	High Blood Pressure
Yes	No	Bleeding	Yes	No	Kidney Disease
Yes	No	Blood Clots	Yes	No	Lupus
Yes	No	Cancer - <i>If yes, what type?</i> _____	Yes	No	Migraine Headaches
Yes	No	Depression	Yes	No	Pace Maker
Yes	No	Drug Dependency	Yes	No	Seizures
Yes	No	Dry Eyes	Yes	No	Sleep Apnea
Yes	No	Diabetes	Yes	No	Stroke - <i>If yes, date:</i> _____
Yes	No	Emphysema	Yes	No	

Please list all major surgeries and/or illnesses you have had: _____

Please circle "Yes" or "NO" if anyone in your family has had a history of any of the following:

Yes	No	Cataracts	Yes	No	Glaucoma
Yes	No	Diabetes	Yes	No	Retinal Problems
Yes	No	Macular Degeneration			

Privacy/Emergency Contact Information

Relative/Friend whom we may contact regarding your visits and/or in the event of an emergency:

1. _____ Relationship _____ Phone #: (____) _____

2. _____ Relationship _____ Phone #: (____) _____

If our office is unable to reach you by phone, may we leave voicemails regarding your appointments?
 Yes No

I certify that I have been provided the Southwest Eye Clinic's Notice of Privacy Practices:

Patient Signature

Date

SWE Employee

Authorization for Release of Information

I, _____, authorize the release of my protected health information to the person or persons named below.

1. _____ Relationship _____ Phone #: (____) _____

2. _____ Relationship _____ Phone #: (____) _____

3. _____ Relationship _____ Phone #: (____) _____

4. _____ Relationship _____ Phone #: (____) _____

5. _____ Relationship _____ Phone #: (____) _____

Information that may be released to the persons listed above:

Financial Information: Yes No

In-Office Information: Yes No

Surgery Information: Yes No

Rights of the Patient

I understand that I have the right to revoke this authorization at any time. I understand that a revocation is not effective in cases where the information has already been disclosed.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing

Patient's Signature _____ Date: _____

Authorization of Care

I authorize Southwest Eye Clinic to examine me and perform such tests and procedures as are reasonable and necessary in the diagnosis and treatment of my care. If I am not the patient, but instead signing on behalf of the patient, I further certify that I am **legally authorized** to sign on the patient's behalf.

Patient's Signature _____ Date: _____

Representative's Signature _____ Date: _____

Relationship of Representative to patient _____