



# The Eye Center

## OF SOUTHERN INDIANA

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Is this your legal name?  YES  NO Legal name: \_\_\_\_\_

Address \_\_\_\_\_  
Street Address City State Zip Code

Gender Assigned at Birth:  Male  Female

Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Unknown

Race:  American Indian or Alaska Native  Asian  Black or African American  
 Native Hawaiian or Other Pacific Islander  Caucasian or White  Other \_\_\_\_\_

Home phone (\_\_\_\_\_) \_\_\_\_\_ Cell phone (\_\_\_\_\_) \_\_\_\_\_ Soc. Security # \_\_\_\_\_

Email address \_\_\_\_\_ Pharmacy \_\_\_\_\_

Are you employed? (Circle one)

Full-time	Part-time	Self-employed	Retired	Military Duty	Not Employed
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Employer \_\_\_\_\_

Employer's address \_\_\_\_\_ Work phone (\_\_\_\_\_) \_\_\_\_\_

Are you a student?  YES  NO (circle one) Full time or Part time

Marital Status (Circle one) 

Single	Married	Widowed	Separated	Divorced	Partner	Other
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Please list an emergency contact (someone NOT living with you)

Name \_\_\_\_\_

Relationship \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Location: \_\_\_\_\_  
First name Last name

Referring Doctor \_\_\_\_\_

Are you a resident of a Temporary Skilled Nursing Facility?  YES  NO

R. Daniel Grossman, M.D. Chad E. Huck, O.D. Steven E. Holbrook, O.D. Warren J. Chang, M.D.

Joseph M. Mackey, M.D. Jason P. Gray, O.D. Frank N. Hrisomalos, M.D. Andrew H. Huck, M.D.

1011 West Second Street Bloomington, Indiana 47403 (812) 334-1213 FAX (812) 333-5039 [www.theeyecenter.org](http://www.theeyecenter.org)

Please see other side

# INSURANCE

## Major Medical Insurance

*(We do not file vision insurance because we are a medical practice.)*

Are you the policy holder?  YES  NO Policy # \_\_\_\_\_ Group # \_\_\_\_\_

If no, name of policy holder \_\_\_\_\_ Relationship \_\_\_\_\_

Policyholder's Date of Birth \_\_\_\_\_ Soc. Security # \_\_\_\_\_

Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

**Do you have a secondary insurance?**  YES  NO

Name of Secondary Insurance \_\_\_\_\_

Are you the policy holder?  YES  NO Policy # \_\_\_\_\_ Group # \_\_\_\_\_

If no, name of policy holder \_\_\_\_\_ Relationship \_\_\_\_\_

Policyholder's Date of Birth \_\_\_\_\_ Soc. Security # \_\_\_\_\_

Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

# RESPONSIBLE PARTY

**Please complete this section if the financially responsible party for this account is someone other than the patient, or if the patient is a minor.**

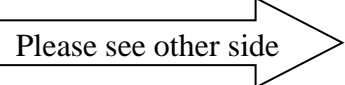
Responsible Party \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Gender:  Male  Female Date of Birth \_\_\_\_\_

Soc. Security # \_\_\_\_\_ Employer \_\_\_\_\_

Email \_\_\_\_\_

Please see other side 

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# MEDICAL HISTORY

**Do you have any of the following eye problems?** *Please check all that apply.*

Cataracts     
  Glaucoma     
  Macular Degeneration     
  Eye trauma  
 Retinal tearing     
  Retinal detachment     
  Glaucoma Suspect     
  Diabetic eye disease  
 Other (please specify): \_\_\_\_\_

**Have you had any of the following eye surgeries?** *Please include the date and which eye.*

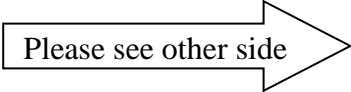
	Date	Date	Surgeon
Cataract	R _____	L _____	_____
After cataract laser	R _____	L _____	_____
Injections to the eye	R _____	L _____	_____
Diabetic laser	R _____	L _____	_____
Glaucoma laser	R _____	L _____	_____
Lasik/PRK	R _____	L _____	_____
Eyelid repair	R _____	L _____	_____

**Do you have any of the following medical conditions?**

AIDS     
  Alzheimer's     
  Arthritis     
  Asthma     
  Back problems     
  Cancer  
 COPD     
  Diabetes type I     
  Diabetes type II     
  Dementia     
  Heart disease  
 High Blood Pressure     
  High cholesterol     
  HIV     
  Kidney disease     
  Osteoporosis  
 Other (please specify): \_\_\_\_\_

**Have you had any of the following surgeries?**

Appendix     
  Tonsillectomy     
  Carpal Tunnel     
  Gallbladder     
  Colonoscopy  
 Heart Bypass     
  Pacemaker     
  Heart stent     
  Heart valve     
  Prostate  
 Knee replacement     
  Knee repair     
  Hip replacement     
  Hysterectomy  
 Mastectomy     
  Biopsies \_\_\_\_\_  
 Other (please specify): \_\_\_\_\_  
 \_\_\_\_\_



# FAMILY HISTORY

**Does your Family have a history of any of the following**

	Mother	Father	Sibling	Child	Grandparent
Cataract					
Glaucoma					
Macular Degeneration					
Retinal Detachment					
Blindness					
Diabetes					
High Blood Pressure					
Heart Disease					
Cancer					

## ALLERGIES

**Do you have any DRUG ALLERGIES?**

YES

NO

Please list all medications you are allergic to.

**Allergies:**

Medication _____	Reaction _____	Severity _____
Medication _____	Reaction _____	Severity _____
Medication _____	Reaction _____	Severity _____
Medication _____	Reaction _____	Severity _____

**Are you allergic to:**

Latex	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Reaction _____
Iodine	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Reaction _____
Shellfish	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Reaction _____

## LIFESTYLE

**Do you drink alcohol?**  Never  Rarely

Socially  Moderately  Heavy

**Smoking Status:**

Never  Current  Former

**Do you drive an automobile?**  YES  NO

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Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

**MEDICATION LIST**

**Please list all medications you are currently taking.  
Include over-the-counter medicines, vitamins and supplements.**

<b>Drug Name</b>	<b>Mg/dose</b>	<b>Purpose</b>

**Are you currently taking any of the following?** Please check all that apply.

Aspirin 81mg     Aspirin Other     Flomax     Tamsulosin     Plavix

*Please let our staff know if you require any special accommodations.  
We look forward to caring for you!*