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

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

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

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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 _____

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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): _____

_____

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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** ☐ YES ☐ NO Reaction _____
Iodine ☐ YES ☐ NO Reaction _____
Shellfish ☐ YES ☐ 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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MEDICATION LIST

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

Drug Name	Mg/dose	Purpose

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!

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