CARTHAGE EYE CLINIC

Please complete all areas below in print.

PATIENT INFORMATION

FIRST MI LAST

NAME_____ **GENDER Male Female**

ETHNICITY (CHOOSE ONE) **AFRICAN AMERICAN**____ **HISPANIC**____ **WHITE**____ **OTHER**_____

STREET CITY, STATE, ZIP

ADDRESS _____

SOCIAL SECURITY # _____ **BIRTH DATE** _____**AGE**_____

EMAIL ADDRESS _____

HOME PHONE _____**CELL PHONE**_____**WORK PHONE** _____

EMPLOYER _____**OCCUPATION** _____

EMERGENCY CONTACT_____**PHONE**_____**RELATIONSHIP**_____

RESPONSIBLE PARTY IF DIFFERENT FROM ABOVE

FIRST MI LAST

NAME_____ **RELATIONSHIP TO PATIENT**_____

ADDRESS _____

SOCIAL SECURITY # _____ **BIRTH DATE** _____

HOME PHONE_____ **CELL PHONE**_____

WORK PHONE_____ **EMPLOYER**_____

MEDICAL INSURANCE INFORMATION

MEDICARE #_____**MEDICAID #**_____

OTHER INS. _____ *Please allow us to make a copy of your cards.*

ACKNOWLEDGEMENT: I understand payment is expected at the time service is rendered. If other arrangements are needed, I will discuss this with a member of the staff. I authorize any insurance company to pay benefits directly to the doctor. I also authorize the release of medical information necessary in handling my claims. I further authorize this office to release or obtain any required medical information to or from any medical facility.

*****Delinquent accounts are subject to interest of 1.5% per month plus collection fees.*****

SIGNATURE: _____ **DATE** _____

over

MEDICAL HISTORY

Your Medical Doctor: _____ Last Medical Exam _____/_____

Allergies to medicines: _____

Medications (include non-prescription): _____

_____

_____

List all major injuries and surgeries: _____

_____

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Do you use alcohol? ☐ No ☐ Rarely ☐ Moderate ☐ Daily

Do you smoke? ☐ No ☐ Rarely ☐ Moderate ☐ Daily

Do you use illegal drugs? ☐ No ☐ Yes If yes, type / how long: _____

Have you ever been exposed to or infected with: ☐ Hepatitis ☐ HIV ☐ Syphilis ☐ Gonorrhea

REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas:

	Circle	
CONSTITUTIONAL		
Fever, Weight Loss/ Gain	Y	N
INTEGUMENTARY (SKIN)	Y	N
NEUROLOGICAL		
Headaches	Y	N
Migraines	Y	N
Seizures	Y	N
Depression	Y	N
VASCULAR/ CARDIOVASCULAR		
Diabetes	Y	N
Cholesterol	Y	N
Heart Trouble	Y	N
High Blood Pressure	Y	N
Vascular Disease	Y	N
EYES		
Loss of Vision	Y	N
Blurred Vision	Y	N
Loss of Side Vision	Y	N
Double Vision	Y	N
Dryness	Y	N
Redness	Y	N
Sandy or Gritty Feeling	Y	N
Itching	Y	N
Burning	Y	N
Foreign Body Sensation	Y	N
Excess Tearing/ Watering	Y	N
Glare/ Light Sensitivity	Y	N
Eye Pain or Soreness	Y	N
Sties or Chalazion	Y	N
Flashes/ Floaters in Vision	Y	N

	Circle	
EAR, NOSE, MOUTH, THROAT		
Allergies/ Hay Fever	Y	N
Sinus Congestion	Y	N
Runny Nose	Y	N
Chronic Cough	Y	N
Dry Throat/ Mouth	Y	N
RESPIRATORY		
Asthma	Y	N
Chronic Bronchitis	Y	N
Emphysema	Y	N
GASTROINTESTINAL		
Diarrhea	Y	N
Constipation	Y	N
Genitourinary		
Genitals/ Kidney/ Bladder	Y	N
BONES / JOINTS / MUSCLES		
Arthritis	Y	N
Muscle Pain	Y	N
Joint Pain	Y	N
LYMPHATIC / HEMATOLOGIC		
Anemia	Y	N
Bleeding Problems	Y	N
Slow to Heal	Y	N
Sickle Cell	Y	N
ENDOCRINE		
Thyroid/ Other Glands	Y	N
Excessive Thirst/ Urination	Y	N
ALLERGIC / IMMUNOLOGIC	Y	N
PSYCHIATRIC	Y	N

Doctor's Signature / Date _____ _____