

WELCOME TO SOUTH EAST EYE SPECIALISTS

We are pleased to welcome you to our office. Please take a few moments to fill out this form as completely as possible. Please be sure to complete both sides of this form and sign where appropriate.

PATIENT INFORMATION

DATE _____

Patient Name _____
Last First Middle Initial

DOB _____ Age _____ Social Security Number _____ - _____ - _____

Sex: Male Female Marital Status: Single Married Divorced Widowed Minor

Preferred Language _____ Race _____ Ethnicity Hispanic Non-Hispanic

Address _____

City _____ State _____ Zip _____

Preferred Contact Type: Home Phone Cell Phone Work Phone Mail Other _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email Address _____

Occupation _____ Employer/School _____

EMERGENCY CONTACT

Name _____ Relationship _____

Home Phone _____ Work Phone _____ Cell Phone _____

ACKNOWLEDGEMENT AND NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received and reviewed the Notice of Privacy Practices pertaining to this office and all of my questions have been answered to my satisfaction in a manner easily understood.

Signature of Patient

Printed Name

Signature of Authorized Representative

Printed Name

Representative's Authority/Relationship to Patient

Witness

Authorization

In compliance with HIPAA's Privacy Rule, it is the policy of this office to allow properly authorized individuals to have access to your protected health information (PHI), which includes your contact lens and/or eyeglass prescription. This authorization will remain in force until otherwise notified by the patient. Please list below any individuals you wish to have access to your protected health information.

1. _____ 2. _____ 3. _____

Please turn over →

EYE HEALTH HISTORY

Name of Eye Doctor _____ Date of last eye exam _____

Do you wear glasses? Yes No How often? _____

Do you wear sunglasses? Yes No What type? Prescription Non Prescription Polarized

Have you ever worn contact lenses? Yes No Are you interested in contact lenses? Yes No

What hobbies do you participate in that may need special visual needs?

List any eye injuries or surgeries that you have had _____

List any eye medications/drops you are currently taking _____

Who in your family has had glaucoma, cataracts, diabetes, macular degeneration, and/or retinal disease?

How did you hear about us? _____

HEALTH HISTORY

Primary Care Physician's name _____ Date of last visit _____

Height _____ Weight _____

Blood Sugar (if applicable) _____ Date Taken _____

A1C (if applicable) _____ Date Taken _____

Do you consume alcohol? Yes No
If yes, how often? Never Rarely Socially Weekly Daily

Do you smoke? Yes No Former Smoker
If yes, how often? More than 1 pack daily Less than 1 pack Daily Socially

List any medications you are currently taking _____

List your allergies to medications or other substances _____

List any major surgical procedures you have had _____
