Retinal Diagnostic Center

Patient Information (PLEASE PRINT)

Circle One: Male / Female Date__________________________

Last Name_______________________**First Name**_____________________Social Security #:__________________

Address: ____ Home Phone #:_____________________________

City: _____________________ State/ Zip Code: _____________ Cell Phone #: ______________________________

Age: __________ Date of Birth: _____________ Marital Status: Single____ Married____ Other__________________

Employer's Name: _______________________________ Occupation: _____________________________________

Employer's Address: ____ Phone #: ________________________

Name of Responsible Party: (if necessary) ____

Address: ____ Home Phone #:_____________________________

City: _____________________ State/ Zip Code: _____________ Cell Phone #: ______________________________

Spouse's Name: Mr. / Mrs. ____

Spouse's Employer's Name: _________________________ Occupation: __________________________________

Address: ____ Home Phone #:_____________________________

City: _____________________ State/ Zip Code: _____________ Cell Phone #: ______________________________

Referring Physician: ____

Address: ____ Phone #:__________________________________

City: _____________________ State/ Zip Code: _____________ Fax #: ___________________________________

Family Physician: ____

Address: ____ Phone #:__________________________________

City: _____________________ State/ Zip Code: _____________ Fax #: ___________________________________

Primary Insurance: __________________________________ Subscriber: _________________________________

Relationship to Patient: ________________ Date of Birth: ____________ Social Security #: _____________________

Group #: _________________________________ I.D. # ____

Secondary Insurance: _________________________________ Subscriber: ________________________________

Relationship to Patient: ________________ Date of Birth: ____________ Social Security #: _____________________

Group #: _________________________________ I.D. # ____

Patient Medical History Information Form

Patient Name:_________________________Date:__________________

Please check appropriate box if you have any history of:

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Thyroid Disease
- ☐ Abnormal Bleeding
- ☐ Seizure
- ☐ Cancer
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Asthma
- ☐ Allergies
- ☐ Prematurity at birth
- ☐ Emphysema
- ☐ Migraine Headaches
- ☐ Smoking

- ☐ Macular Degeneration
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Retinal Detachment
- ☐ High Myopia
- ☐ Lazy eye, Stabismus/Amblyopia
- ☐ Eye Surgery
- ☐ Other Eye Problems: _______________
  ____
  ____
  ____

In case of emergency please call: ____

Phone Number:_________________Relationship to patient:____________________

Family eye problems:

- ☐ Glaucoma
- ☐ Retinal Detachment
- ☐ Macular Degeneration
- ☐ Retinitis Pigmentosa
- ☐ High Myopia
- ☐ Other:____

Are you allergic to any medication? ☐ Yes ☐ No If Yes, what medicine:_________
____
____

Please list all current medications:____
____
____
____