PATIENT INFORMATION							
First Name:		M.I.:		Last Name:			
Nickname:		DOB:		Marital Status:		Sex:	☐M ☐F
Address:							
City:		State:		Zip Code:		SSN:	
Home Phone:		Cell Phone:					
Work/Other Phone:		Email:					
Occupation/Grade:							
Employer/School:							
Best way to contact you?		Would you like Text Reminders?	☐Yes ☐No				
How did you hear about us?							

PHYSICIAN INFORMATION			
Primary Care Physician		Referring Physician (if applicable)	

PARENT/LEGAL GUARDIAN/PRIMARY INSURANCE HOLDER INFORMATION							
First Name:		M.I.		Last Name:			
Relationship to Patient:		DOB:		SSN:			
Address:							
City:		State:		Zip Code:			
Home Phone:		Cell Phone:					
Employer:		Work Phone:					
Emergency Contact:		Phone:					

INSURANCE INFORMATION					
	Insurance Company:	ID Number:	Subscriber:	Subscriber ID:	Subscriber DOB:
Vision:					
Medical:					

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES	
By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices for this office.	
X	Date:

- I request that payment of authorized insurance benefits for any services furnished me, be made on my behalf to Carmel Eyecare.
- I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.

X	Date:

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PATIENT HISTORY QUESTIONNAIRE					
How is your general health?					
Do you have problems with any of these systems? (Please check all that apply)					
Gastrointestinal	☐ Y ☐ N	Nervous	☐ Y ☐ N	Eyes	☐ Y ☐ N
Ears/Nose/Throat	☐ Y ☐ N	Genitourinary	☐ Y ☐ N	Skin	☐ Y ☐ N
Cardiovascular	☐ Y ☐ N	Musculoskeletal	☐ Y ☐ N	Mental	☐ Y ☐ N
Respiratory	☐ Y ☐ N	Endocrine (glands)	☐ Y ☐ N	Allergic/Immune	☐ Y ☐ N
Blood/Lymph	☐ Y ☐ N				
If yes, please explain:					
Please answer all that apply:					
Diabetes? ☐ Y ☐ N	Type:	Date of Diagnosis:			
Allergies? ☐ Y ☐ N	Allergic to what?	What happens?			
Medication Allergy? ☐ Y ☐ N	Medication name and reaction:				
Other health problems:					
Current Medications:					
Do we have your permission to access your medication history with our e-prescribing system? ☐ Y ☐ N					
Have you had any operations? ☐ Y ☐ N	Type:	Date:			
Do you use cigarettes? ☐ Y ☐ N	Chewing Tobacco? ☐ Y ☐ N	Alcohol? ☐ Y ☐ N			
Do you use other substances? ☐ Y ☐ N	If yes, please list the substance:				
Name of Family Doctor?	Date of last visit?				
Date of last tetanus shot?					
Do you have an Advance Directive for health care (Living Will)?					

FAMILY HISTORY (Relationships)			
High Blood Pressure? ☐ Y ☐ N	Relation:	Diabetes? ☐ Y ☐ N	Relation:
Macular Degeneration? ☐ Y ☐ N	Relation:	Glaucoma? ☐ Y ☐ N	Relation:
Retinal Detachment? ☐ Y ☐ N	Relation:	Cataracts? ☐ Y ☐ N	Relation:
Other eye condition? ☐ Y ☐ N	What kind?		

PERSONAL EYE INFORMATION		
Have you had any eye operations? ☐ Y ☐ N	Type:	Date:
Have you had an eye injury? ☐ Y ☐ N	Type:	Date:
Do you have glaucoma? ☐ Y ☐ N	Cataracts? ☐ Y ☐ N	Dry Eyes? ☐ Y ☐ N
Do you have blurred vision? ☐ Y ☐ N	When:	
Do you wear glasses? ☐ Y ☐ N	Contact Lenses? ☐ Y ☐ N	Type:
Additional Information:		
Whom may we thank for referring you?		
Doctor's Initials:		