Hazleton Eye Specialists
Stroudsburg Eye Specialists

PATIENT INFORMATION FORM

Please print/complete and bring in at your appointment

First Name _____ Last Name _____ Middle Initial _____

Date of Birth _____ Age _____ Sex _____ Marital Status (circle one) Married / Single

Street Address _____ State _____ Zip _____

Home Phone # _____Cell Phone # _____ Work Phone #_____

Email address: _____

Referred by *(please circle one):* Internet, Newspaper, Commercial / TV, Phone book, Doctor (name) _____, Friend (name) _____

Employment

Employment Status (circle one): Employed / Self Employed / Not Working Occupation: _____

Employer _____ Employer Phone # _____

Employer Address _____ State _____ Zip _____

Other Contact Information

Person Responsible for Charges? (if not patient) _____ Relationship to Patient _____

Home Phone # _____

Emergency Contact Information

Who should we contact in case of an emergency? _____ Relationship to Patient _____

Home Phone # _____ Cell Phone # _____ Work Phone #_____

Eye-Health- Patient (check all that apply)

- □ Amblyopia
- □ Blurred Vision Far
- □ Blurred Vision – Near
- □ Burning Eyes
- □ Cataracts
- □ Double / Distorted Vision
- □ Drooping Eyelid
- □ Dry Eyes
- □ Eye Surgeries
- □ Eye Turn
- □ Floaters / Spots
- □ Fluctuating Vision
- □ Foreign Body Sensation
- □ Glaucoma
- □ Glare / Light Sensitivity
- □ Headaches
- □ Itchy Feeling
- □ Infection of Eye / Lid
- □ Loss of Vision – Central
- □ Loss of Vision – Side
- □ Mucus / Discharge
- □ Redness
- □ Retinal Detachment
- □ Tearing / Watery Eyes

General-Health- Patient (check all that apply)

- □ Allergies / Hay fever
- □ Asthma / Respiratory
- □ Blood Disorders
- □ Cancer
- □ Cardiovascular/ High B.P
- □ Chronic Bronchitis
- □ Chronic Cough
- □ Diabetes
- □ Emphysema
- □ Gastrointestinal Problems
- □ Heart Attack / Stroke
- □ Headaches / Migraines
- □ Kidney Disease
- □ Psychiatric / Depression
- □ Rheumatoid Arthritis
- □ Thyroid/ Endocrine Disease
- □ Skin Disorders
- □ Weight Loss / Gain

Family History- Blood Relatives (check all that apply)

□ Amblyopia (Lazy Eye)	□ Color Blindness	□ High Cholesterol
□ Arthritis	□ Diabetes	□ Macular Degeneration
□ Blindness	□ Eye Turn	□ Retinal Detachment
□ Cancer	□ Glaucoma	□ Stroke / Heart Attack
□ Cataract(s)	□ High Blood Pressure	□ Thyroid Disease

Name of Family Physician _____ Physician's Phone Number_____

Medications/Vitamins/Supplements – Enter all medications/Vitamins/Supplements taken by the patient and for what condition each is taken for.

Medication/Vitamins/Supplements	Condition
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Please answer the following Questions:

1. Are you Pregnant or Nursing? Yes / No
2. Do you have trouble driving at night? Yes / No
3. Do you wear glasses? Yes / No Do you wear Contacts? Yes / No (If yes) what type of contacts _____
4. Do you experience blur, headaches or eyestrain with computers use? Yes / No
5. Are you interested in Laser (refractive) surgery to correct your vision? Yes / No

Vision Insurance Information

Name of Vision Plan _____ Patient Relationship to insured _____
Insured ID number _____ Insured's Date of Birth _____
Insured's Name _____ Insured's Phone # _____

Medical Insurance Information

Name of Medical Insurance _____ Patient Relationship to insured _____
Insured ID number _____ Insured's Date of Birth _____
Insured's Name _____ Insured's Phone # _____

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Photography Consent

Your annual eye exam at Stroudsburg Eye Specialists / Hazelton Eye Specialists includes an examination of the back of your eye. This examination is important in the early detection of disorders which may be harmful to your vision, including Glaucoma, high blood pressure, Diabetes, and Macular Degeneration. There are two available options for this exam.

***Option 1 (Recommended) – Digital Retinal Photography**

Digital Retinal Photography can be performed without dilation of your eyes and is more comfortable for you. The benefits to Digital Retinal Photography are:

- No light sensitivity
- No stinging
- No drops
- Maintain a digital record of the back of your eye

There is a nominal charge of $40.00 for this service that will likely not be covered by insurance.

* *Dilation may still be performed if deemed medically necessary*

Option 2 – Dilation

Dilation involves opening your Pupils with drops so that the doctor can look at the back of your eye. Dilation has the following drawbacks:

- Requires eye drops
- Blurry near vision
- Possible stinging
- Light Sensitivity

Please check one of the options below:

_____ I accept Retinal Photography at a cost of $40.00

_____ I accept Dilation

Patient name (Print) _____

Patient signature _____ Date: _____