Hazleton, Stroudsburg & Pottsville 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 _____ City _____ State _____ Zip _____

Home Phone # _____Cell Phone # _____ Work Phone #_____

Email address: _____ Social Security Number: _____

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 Cough
- ☐ Diabetes
- ☐ Emphysema
- ☐ Gastrointestinal Problems
- ☐ Heart Attack / Stroke
- ☐ Kidney Disease
- ☐ Psychiatric / Depression
- ☐ Rheumatoid Arthritis
- ☐ Thyroid/ Endocrine Disease
- ☐ Skin Disorders

☐ Chronic Bronchitis ☐ Headaches / Migraines ☐ 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 # _________________________