

BRUCE L. HAMMONDS, O.D., P.C.

Patient Information

Dr. Mr. Mrs. Ms.

Male Female

Preferred

Name: _____ Birth Date: ___/___/___ Name: _____

Address: _____ Home phone: _____

City _____ State _____ Zip _____ Pager or Cell # _____

Social Security # _____ Email: _____

Marital Status : Married Divorced Widowed Single Separated

Your Employer _____ Occupation _____ Work # _____

Spouse's Name _____ Birth Date _____ S.S # _____

Spouse's Employer _____ Occupation _____ Work # _____

Last Eye Exam: _____ / _____ Name of Doctor _____

Whom may we thank for referring you to our office _____

Nearest Relative (not living with you)

Name _____ Phone# _____

Address _____ City _____ State _____ Zip _____

Insurance Information (Primary)

Name of Insured _____ Relationship to Patient _____

Insured's Date of Birth _____ Insurance Company _____

DO YOU HAVE ADDITIONAL INSURANCE (SECONDARY)?

NO YES IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insured _____ Relationship to Patient _____

Insurance Company _____

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eye care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor or ophthalmic group insurance benefits otherwise payable to me. I understand that my eye care insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services on my behalf or my dependents.

X _____ Date _____

SIGNATURE OF PATIENT

Patient: _____ Date: _____

REVIEW OF HEALTH SYSTEMS ◆ (ROS)

◆ **EYES** Have you had or do you have any of the following?

Glaucoma:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do You Wear Glasses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do You Wear Contacts?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dry Eyes:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do You Drive?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other eye problems:	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Please describe any problems with the following health systems:

◆ GASTROINTESTINAL <input type="checkbox"/> No Problem <input type="checkbox"/> Ulcer <input type="checkbox"/> Colitis <input type="checkbox"/> Reflux <input type="checkbox"/> Diarrhea <input type="checkbox"/> Heartburn	◆ NEUROLOGICAL <input type="checkbox"/> No Problem <input type="checkbox"/> Epilepsy <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Headaches <input type="checkbox"/> Numbness
◆ EARS/NOSE/THROAT <input type="checkbox"/> No Problem <input type="checkbox"/> Upper Respiratory Infection <input type="checkbox"/> Sinusitis <input type="checkbox"/> Chronic Colds	◆ CONSTITUTIONAL <input type="checkbox"/> No Problem <input type="checkbox"/> Fever <input type="checkbox"/> Weight Loss <input type="checkbox"/> Fatigue <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Trauma
◆ CARDIOVASCULAR <input type="checkbox"/> No Problem <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Stroke <input type="checkbox"/> Vascular Disease <input type="checkbox"/> Chest Pain <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Heart Disease	◆ MUSCULOSKELETAL <input type="checkbox"/> No Problem <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Joint Pain <input type="checkbox"/> Muscle Ache
◆ RESPIRATORY <input type="checkbox"/> No Problem <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> Wheezing <input type="checkbox"/> Coughing	◆ INTEGUMENTARY <input type="checkbox"/> No Problem <input type="checkbox"/> Psoriasis <input type="checkbox"/> Eczema <input type="checkbox"/> Rashes <input type="checkbox"/> Acne <input type="checkbox"/> Excessive Dryness <input type="checkbox"/> Cancer
◆ ALLERGIC/IMMUNE <input type="checkbox"/> No Problem <input type="checkbox"/> Allergies _____ <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Lupus <input type="checkbox"/> HIV	◆ ENDOCRINE <input type="checkbox"/> No Problem <input type="checkbox"/> Thyroid Dysfunction <input type="checkbox"/> Hormonal Dysfunction <input type="checkbox"/> Type 1 Diabetes <input type="checkbox"/> Type 2 Diabetes
◆ BLOOD/LYMPH <input type="checkbox"/> No Problem <input type="checkbox"/> Anemia <input type="checkbox"/> Leukemia	◆ PSYCHIATRIC (MENTAL) <input type="checkbox"/> No Problem <input type="checkbox"/> Depression <input type="checkbox"/> Bipolar <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Anxiety
◆ GENITOURINARY <input type="checkbox"/> No Problem <input type="checkbox"/> STD <input type="checkbox"/> Bladder Infection <input type="checkbox"/> Blood in Urine	

PAST, FAMILY, & SOCIAL HISTORY ★ (PFSH)

★ **PATIENT PAST HISTORY**

Have you had any eye operations? Yes No Date: _____ Type: _____

Have you had an eye injury? Yes No Date: _____ Type: _____

Have you had a retina detachment? Yes No Date: _____ Type: _____

Name of family doctor: _____

★ **SOCIAL HISTORY**

Do you use alcohol? Yes No Amount: _____

Do you use tobacco? Yes No Amount: _____

Do you use other substances? Yes No What: _____

Describe any special visual needs: _____

Are You: Pregnant Nursing

List Drug Allergies: _____

★ **Family History** Do any family members have any of the following problems:

High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship _____	Macular Degeneration	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship _____
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship _____	Retinal Detachment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship _____
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship _____	Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship _____
Other eye condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship _____	Description: _____		

Patient Signature: _____

Date Reviewed _____ Changes _____

No Changes _____

No Changes _____

No Changes _____

No Changes _____

List all medications:(oral, drops, patches, etc...)
