ARMSTRONG COLT GEORGE COHEN OPHTHALMOLOGY

PATIENT INFORMATION:
MR____ MRS____MISS____MS___NAME_____
BIRTHDATE__/__/_____AGE____MALE___FEMALE___SOCIAL SECURITY #_____
ADDRESS_____
CITY_____STATE_____ZIP CODE_____
HOME PHONE_____WORK PHONE_____MOBILE PHONE_____
EMAIL ADDRESS_____OCCUPATION_____
EMPLOYER NAME/ADDRESS_____
SPOUSE OR PARENTS NAME_____FAMILY DOCTOR_____
WHO CAN WE THANK FOR REFFERING YOU TO OUR PRACTICE_____

Are you diabetic? If so, **TYPE 1** or **TYPE 2** (please circle)
What year were you diagnosed?_____
Have you ever seen a diabetes educator/nutritionist? **YES** or **NO** (please circle)
If known, what was your last A1C?_____

Have you received a pneumonia vaccination? **YES** or **NO** (please circle)
Have you received a FLU vaccination this season? **YES** or **NO** (please circle)

What is your preferred language?_____
Ethnicity (please circle): **HISPANIC OR LATINO** or **NON HISPANIC OR LATINO**
Race (please circle): **AMERICAN INDIAN**
ASIAN
BLACK or **AFRICAN AMERICAN**
HISPANIC
WHITE
OTHER
Smoking status (please circle): **CURRENT SMOKER FORMER SMOKER NEVER SMOKER**

INSURANCE INFORMATION

SUBSCRIBER NAME:_____SUBSCRIBER DOB:___/___/_____
SUBSCRIBER ADDRESS (IF DIFFERENT THAN ABOVE):_____
_____
INSURANCE CO. NAME(S)_____
ID#_____GROUP#_____

We must have your permission to bill your insurance company for services rendered by Armstrong Colt George Cohen Ophthalmology. We must have your signature on file. Please sign the statement below. *Sign your name on the patient signature line only.* We are required by law to have your signature. If you do not sign this form, we will be unable to bill your insurance company and provide services for you today. Thank you.

"I authorize any holder of my medical information be released to my Medicare and/or insurance carrier and it's agents--for the purpose of determining benefits payable either to me, or to the provider who rendered my services at Armstrong Colt George Cohen Ophthalmology. By signing this statement I am giving my permission to bill my Medicare and/or other insurance carrier. I also understand I will be responsible for any outstanding balances that are not covered by my insurance carrier".

PATIENT SIGNATURE_____**DATE**_____

REASON FOR VISIT:_____
MEDICATION ALLERGIES:_____
DAILY MEDICATIONS:_____

Patient past medical history (circle condition or circle no health problems)

ANXIETY
ARTHRITIS
ASTHMA
BLEEDING DISORDER
BYPASS
CANCER
DEPRESSION
DIABETES_____YEARS
EMPHYSEMA
HEART ATTACK
HEART MURMUR
HEPATITIS
HIGH BLOOD PRESSURE
IRREGULAR HEARTBEAT
LEUKEMIA
LUPUS
MULTIPLE SCLEROSIS
NUMBNESS/TINGLING
SARCOID
SINUSITIS
STROKE
THYROID DISORDER
SURGERIES:_____
_____
OTHER:_____
_____
NO HEALTH PROBLEMS

<u>FAMILY HISTORY</u> (circle all that apply)
BLINDNESS (REASON_____)
DIABETES
GLAUCOMA (WHO_____)
MACULAR DEGENERATION
RETINAL DETACHMENT
STROKE
NO HISTORY OF EYE DISEASE

<u>SOCIAL HISTORY</u>
DO YOU DRINK ALCOHOL? YES or NO
AMOUNT_____

<u>OCULAR HISTORY OF PATIENT</u> (circle all that apply to you or circle none)
AMBLYOPIA / BLINDNESS / CATARACTS / CATARACT SURGERY DONE / EYE INJURY/ GLAUCOMA / IRITIS / MACULAR DEGENERATION / RETINAL DETACHMENT / STRABISMUS / SURGERY DONE _____NO EYE PROBLEMS

<u>REVIEW OF SYSTEMS</u> (circle condition you have or circle none)

<u>EYES</u> -BLURRY VISION / DISTORTED or WAVY VISION / DOUBLE VISION / DRYNESS / FLASHES / FLOATERS / GLARE / HALOS / ITCHING / IRRITATION / LOSS OF VISION / PAIN IN OR AROUND EYE / REDNESS / TEARING/ OTHER:_____/ NONE

<u>CONSTITUTIONAL</u>- FEVER / WEIGHT LOSS / WEIGHT GAIN / NONE
<u>EARS, NOSE, & THROAT-</u> COUGH / HEARING LOSS / JAW PAIN / RUNNY NOSE / SCALP TENDERNESS / SINUS PROBLEMS / SORE THROAT / NONE

<u>RESPIRATORY</u>- ASTHMA / EMPHYSEMA / SHORTNESS OF BREATH / NONE

<u>CARDIOVASCULAR</u>- CHEST PAIN / HEART ATTACK / HIGH BLOOD PRESSURE / HIGH CHOLESTEROL / NONE

<u>GASTROINTESTINAL</u>- HERNIA / HEPATITIS____ / JAUNDICE / ULCER_____ / NONE
<u>GENITOURINARY</u>- CANCER- OVARIAN, UTERINE, PROSTATE / KIDNEY DISEASE/ NONE
<u>INTEGUMENTARY-</u> BREAST DISEASE or CANCER / SKIN DISEASE or CANCER / NONE

<u>ENDOCRINE</u>- DIABETES_____ / THYROID DISEASE / NONE
<u>HEMATOLOGIC/LYMPHATIC</u>- BLOOD DISORDER / CANCER _____ / LEUKEMIA / NONE
<u>NEURO/PSYCHIATRIC</u>-AGITATION / ANXIETY / DEPRESSION / STROKE / OTHER_____/NONE
<u>IMMUNOLOGIC/ALLERGIC</u>- IMMUNE SYSTEM DISEASE / LUPUS / OTHER_____/NONE
SEASONAL ALLERGIES / OTHER ALLERGIES_____/NONE