Patient Form

Smallwood Eye Associates

Appointment Date: _____

Welcome to our Clinic — For **faster service**, please complete the following form prior to arriving at our office

Patient's Name (please print): _____

If a Child, Parent's Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

E-mail Address: _____

Birth Date: _____ M or F: _____ SSN: _____

Employer: _____ Occupation: _____

Spouse's Employer: _____ Work Phone: _____

Health Insurance Carrier: _____ Policy # _____

Medicare/Medicaid: _____ Policy # _____

How did you find out about our office? _____

Date of Last Eye Exam: _____ Name of Previous Eye Doctor: _____

Do you have problems with any of these systems?

- ☐ Gastrointestinal
- ☐ Ear/Nose/Throat
- ☐ Cardiovascular
- ☐ Respiratory
- ☐ Headaches
- ☐ Nervous System
- ☐ Genitourinary
- ☐ Musculoskeletal
- ☐ Skin
- ☐ Mental
- ☐ Endocrine (Glands)
- ☐ Blood/Lymph
- ☐ Allergic/immunologic

Surgeries (What type & when) _____

Any allergic reactions to medications or other substances? ☐ Yes ☐ No

If yes, please list _____

Name of general physician _____

Do you smoke?	☐ Yes ☐ No	How much? _____
Do you drink alcohol?	☐ Yes ☐ No	How much? _____
Do you use any other substances?	☐ Yes ☐ No	How much? _____
Do you take medications?	☐ Yes ☐ No	Please list names and how often: _____

_____

Do you have family history of any of the following?

- ☐ Diabetes
- ☐ Macular Degen.
- ☐ Glaucoma
- ☐ Retinal Detachment
- ☐ Wear Glasses
- ☐ Cataracts

Please explain any boxes you have checked _____

_____

Do you have any of the following?

- ☐ Dry Eyes
- ☐ Blurred Vision
- ☐ Eye Surgeries
- ☐ Eye Injuries
- ☐ Wear Glasses
- ☐ Wear Contacts

Any eye problems at this time? Please explain _____

_____

Are you interested in laser vision correction? ☐ Yes ☐ No

I authorize the release of any medical information necessary to provide the most beneficial and complete visual examination. I understand that I am financially responsible for all charges whether or not paid by insurance. Payment is due at the time services are rendered.

Signature: _____ **Date** _____