

**SUNCOAST EYE CENTER
PATIENT INFORMATION**

NAME: _____ SEX: _____ AGE: _____ DATE: _____

PRESENT ADDRESS: _____ DATE OF BIRTH: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ SINGLE: _____ MARRIED: _____ WIDOWED: _____

RACE: *WHITE* _____ *BLACK* _____ *AMERICAN INDIAN* _____ *HISPANIC* _____ *OTHER* _____

SOCIAL SECURITY NO: _____ SPOUSE OR PARENT'S NAME: _____

WORK INFORMATION

EMPLOYER: _____ BUSINESS PHONE: _____

EMPLOYERS ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

POLICY HOLDER NAME: _____ CERTIFICATE NO: _____

POLICY HOLDER - DATE OF BIRTH: _____ SOCIAL SECURITY NO: _____

SECONDARY INSURANCE COMPANY: _____

POLICY HOLDER NAME: _____ CERTIFICATE NO: _____

POLICY HOLDER - DATE OF BIRTH: _____ SOCIAL SECURITY NO: _____

IS YOUR INSURANCE AN HMO? YES _____ NO _____

DOES YOUR INSURANCE REQUIRE A REFERRAL? YES _____ NO _____

If yes, do you have a referral? YES _____ NO _____

REFERRAL INFORMATION

HOW WERE YOU REFERRED TO THE SUNCOAST EYE CENTER?

Optometrist _____ *If so, Name:* _____

Other Physician _____ *If so, Name:* _____

Friend/Family _____

Advertisement _____

Yellow Pages _____

Screening _____

Other _____ *If so, Name:* _____

NAME OF FAMILY PHYSICIAN: _____

MEDICAL HISTORY

DO YOU HAVE ANY OF THE FOLLOWING PROBLEMS?

	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
Diabetes	_____	_____	Heart Disease	_____	_____
High Blood Pressure	_____	_____	Cancer	_____	_____
Emphysema	_____	_____	Epilepsy	_____	_____
Bleeding Tendencies	_____	_____	Asthma	_____	_____
Shortness of Breath	_____	_____	Hepatitis	_____	_____
Nervous Disorder	_____	_____	HIV	_____	_____
Do you Smoke?	_____	_____	Do you drink Alcohol?	_____	_____
Usage: _____ pk/day			Usage: _____		
Other: _____					

HAVE YOU HAD ANY PREVIOUS SURGERY? YES _____ NO _____

If yes, what type? _____

HAVE YOU HAD ANY PREVIOUS PROBLEMS WITH YOUR EYES? YES _____ NO _____

If yes, what type of problem? _____

HAVE YOU HAD ANY EYE SURGERY? YES _____ NO _____

If yes, list type and date of surgery: _____

DOES YOUR FAMILY HAVE A HISTORY OF EYE DISEASE? YES _____ NO _____

If yes, Explain: _____

MEDICATION INFORMATION

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES _____ NO _____

If yes, list: _____

ARE YOU PRESENTLY ON ANY MEDICATIONS? YES _____ NO _____

If yes, list medication and dosage:

_____	_____
_____	_____
_____	_____
_____	_____

PATIENT'S SIGNATURE: _____