The Eye Studio
PATIENT INFORMATION SHEET

DATE_____

LAST NAME_____

FIRST NAME_____MIDDLE INITIAL_____

NICK NAME_____

TITLE: ☐ Mr. ☐Mrs. ☐Miss ☐Dr.☐ Capt. SEX: ☐M ☐F

SSN_____

Age _____ **Patient Birth Date**_____

Address_____

City_____ **ST** ____ **ZIP**_____

Cell#_____

Home# _____

Email_____

Employer_____ ☐Retired

Occupation_____

Preferred Language: ☐ English ☐ Spanish ☐ Other_____

Race: ☐ American Indian or ☐ Alaska Native ☐ Asian
☐ African American ☐ Caucasian ☐ Hispanic
☐ Native Hawaiian or Other Pacific Islander
☐Other_____

Ethnicity: ☐ Not Hispanic or Latino ☐Hispanic or Latino
☐Native Hawaiian or Other Pacific Islander

Preferred method of communication: ☐Phone ☐Text ☐Email

Person legally and financially responsible for patient:

_____

Person's relationship to the patient: _____

How did you hear about us: ☐Walk in ☐Internet ☐ Insurance
☐ Instagram ☐Facebook ☐Patient referral ☐DR. referral

If referred, name of patient or Doctor: _____

PLEASE ENTER YOUR INSURANCE INFORMATION

VISION Insurance_____

Member ID _____ Group# _____

MEDICAL Insurance _____

Member ID_____ Group# _____

Insured's (Primary) Name_____ ☐Self

Birth Date _____SS#_____

(SELF PAY & INSURANCE) ASSIGNMENT AND RELEASE

I certify that I and/or my dependents have insurance coverage with the above-named compan(ies). By signing below, I authorize payment of insurance benefits be made on my behalf to Dr. Mona Patel OD, LLC for services rendered. I understand that I am financially responsible for all items not paid by my insurance company FOR ANY REASON. I hereby authorize the doctor to release any information needed to Secure payment of benefits.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE

MEDICAL HISTORY

REASON FOR TODAY'S VISIT: _____**Time since last exam**: _____Years _____ Months

List your allergies to medications or other substances (including latex) _____

List any eye injuries and surgeries you have experienced _____

List all medications and dosages _____

_____

Do you drive? ☐Yes ☐No If yes, do you have visual difficulty when driving? ☐Yes ☐ No

Do you wear glasses? ☐Yes ☐No Type of glasses: ☐Distance Rx ☐Readers ☐Bifocals ☐Progressives ☐Store – Bought Readers

Do you wear contact lenses? ☐ Yes ☐No Type of contacts: ☐Soft ☐Rigid ☐Astigmatism / Toric ☐Multifocal Brand: _____

Are you planning to purchase eyeglasses today? ☐Yes ☐ No Are you planning to purchase contacts today? ☐Yes ☐No

Your Primary Care Physician: _____ Other Physician (specialist, etc.): _____

Social History *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

☐Yes, I would rather discuss my Social History information (the following questions) directly with my doctor (check box)

Are pregnant or nursing? ☐ Yes ☐No

Do you use tobacco products? ☐ Yes ☐No Type: _____ How often: _____ How long _____(Years)

Do you drink alcohol? ☐ Yes ☐No Type: _____ How often: _____ How long _____(Years)

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Family History (living or deceased)

Disease/Condition	Father	Mother	Brother	Sister	Son	Daughter
Cancer_____(Type)	☐	☐	☐	☐	☐	☐
Diabetes: Type 1 2	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Thyroid Disease: Hyper Hypo	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
Cataract	☐	☐	☐	☐	☐	☐
Macular Degeneration	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐

Review of Systems: Do you have any of the following? (Please list any **treatments** or **medication**(s) under condition.)

Eyes:
- Cataracts ☐
- Macular Degeneration ☐
- Glaucoma ☐
- Diabetes ☐
- Diabetic Retinopathy ☐
- Dry Eyes ☐
- Eye Infection, Inflammation ☐
- Eye Allergies ☐
- Floaters in Vision ☐
- Flashes of Light ☐
- Iritis or Uveitis ☐
- Retina Defect or Degeneration ☐
- Redness ☐
- Burning ☐
- Itching ☐
- Tearing ☐
- Discharge ☐
- Blurred Vision ☐
- Eyestrain ☐
- Eye pain ☐
- Light Sensitivity ☐
- Headaches ☐
- Poor Night Vison ☐
- Bothersome ☐
- Nighttime Glare ☐
- Double Vision ☐
- Total Loss of Vision ☐

_____
_____
_____
_____

Constitutional:
- Developmental Disability ☐
- Fatigue Syndrome ☐
- Cancer: _____(Type) ☐

Ear, Nose, Mouth and Throat:
- Hearing Impaired ☐
- Sinusitis ☐
- Dry Mouth ☐

Neurological:
- Headaches ☐
- Migraines ☐
- MS ☐
- Seizures ☐

Cardiovascular:
- High Blood Pressure ☐
- Stroke ☐
- Heart Disease ☐
- Elevated Cholesterol ☐

Respiratory:
- Asthma ☐
- COPD ☐
- Emphysema ☐

Gastrointestinal:
- Chron's Disease ☐
- Ulcerative Colitis ☐

Genitourinary
- Kidney Disease/Disorder ☐
- Prostate Disease ☐

Musculoskeletal:
- Rheumatoid Arthritis ☐
- Osteoarthritis ☐
- Fibromyalgia ☐

Integumentary: (Skin)
- Eczema ☐
- Rosacea ☐
- Psoriasis ☐

Endocrine:
- Diabetes Type 1 ☐
- Diabetes Type 2 ☐
- Thyroid Disease/Disorder ☐

Hematologic/Lymphatic: (Blood Disorder)
- Anemia ☐

Immunologic/Allergy:
- Lupus ☐

Psychiatric:
- Depression ☐

List any conditions and medications not listed above: _____