WALKER EYE CLINIC

GENERAL INFORMATION:

Legal Name_____ Preferred Name, if different: _____
Address_____ City _____ State____ Zip_____
Email_____ Occupation_____
Date of Birth_____/_____/_____ Age_____ Sex_____
Phone: ( ) _____ - _____

PRIMARY CARE PHYSICIAN_____

Responsible Party (if under 18)_____

INSURANCE INFORMATION:
Primary Insurance: _____Policy Number:_____
Name of primary cardholder: (if different from patient)_____
Relationship to Patient_____ SSN: ____ - ____ - ____ DOB: ___ /___ / _____
Phone (if different): ( ) _____ - _____
Address (if different: _____

VISION INFORMATION: (Please Circle)
Do you wear glasses? Y/N Have you been prescribed bifocals? Y/N
Do you wear or are you interested in contact lenses? Y/N

PERSONAL MEDICAL HISTORY:
SYSTEMIC: (Circle any that apply)

Diabetes	High Blood Pressure	Heart Disease	High Cholesterol	Kidney Disease
Cancer	Arthritis	Stroke	Shingles	Thyroid Disease
Sleep Apnea	Seasonal Allergies	Epilepsy	Migraines/Headaches	
Hormonal Dysfunction	Autoimmune Disorders	Skin Disorder	Breathing Disorder	
Autism	ADHD	Mental Disorder		

Other:_____

OCULAR: (Circle any that apply)

Cataracts	Dry Eye	Macular Degeneration	Diabetic Retinopathy	Glaucoma
Retinal Disease	Iritis/Uveitis	Eye Infection	Discharge	Poor Night Vision
Light Sensitivity	Floaters/Flashes	Glare	Blurred Vision	Double Vision
Burning/Itching	Eye Strain/Eye Pain	Loss of Vision	Watering	Redness

Other:_____

SURGICAL HISTORY: (EYE Surgeries ONLY)

Procedure	Date Performed	Doctor / Surgeon
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____

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FAMILY MEDICAL HISTORY

Cancer Y / N Type and family member(s):_____

Diabetes Y / N Family member(s):_____

High Blood Pressure Y / N Family member(s):_____

FAMILY OCULAR HISTORY

Cataracts (prior to age 60) Y / N Family member(s):_____

Macular Degeneration Y / N Family member(s):_____

Glaucoma Y / N Family member(s):_____

SOCIAL HISTORY:

Do you use Alcohol? Yes / No / Formerly How Often:_____

Do you use Tobacco? Yes / No / Formerly Type:_____ How Often:_____

Do you use Recreational Drugs? Yes / No / Formerly

ALLERGIES:

Drug Allergies: Y / N

1._____Reaction_____

2._____Reaction_____

3._____Reaction_____

MEDICATIONS:

____ I DO NOT TAKE ANY MEDICATIONS

Please list ALL medications you are currently taking

1._____

2. _____

3._____

4._____

5._____

6._____

PATIENT CONSENT AND RECEIPT OF PRIVACY PRACTICES (HIPPA)

(To be completed by **ALL PATIENTS** or parent/guardian if patient under 18)

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) requires that all health care records and other individually identifiable health information used or disclosed to us in any form, be kept confidential. The federal law gives you significant rights to understand and control how your information is used. As required by HIPPA, we have prepared an explanation, which is attached, describing how we are required to maintain the privacy of your health information. I also understand that I may revoke this consent by written request at any time. If revoked, it is understood by all parties that all information released prior to being notified of such revocation was made with my consent. By signing this I acknowledge that I have read the attached document and understand its contents I acknowledge that I have read and understand Walker Eye Clinic's Notice of Privacy Practices.

Signature (patient or parent/guardian) _____ Date: _____