PATIENT INFORMATION QUESTIONNAIRE

Patient Full Name: _____ Birth Date: ____/____/____ SS# ___-__-_____
Mailing Address: _____ City/State/Zip: _____
E-Mail Address: _____Home #:_____Mobile #:_____
Employer: _____Occupation:_____Work Phone: _____
Sex: (Circle One) MALE FEMALE
Preferred Language: (Circle One) ENGLISH SPANISH **Primary Care Physician**:_____
Race: (Circle One) AMERICAN INDIAN OR ALASKAN NATIVE ASIAN **Ethnicity:** (Circle One) HISPANIC OR LATINO
NATIVE HAWAIIAN WHITE/CAUCASIAN BLACK/AFRICAN AMERICAN NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER
HISPANIC OTHER:_____ NON HISPANIC OR LATINO

How did you hear about us? (Circle One) RADIO ADVERTISEMENT INTERNET SEARCH WALK-IN YELLOW PAGES
REFERRAL (FROM?)_____ OTHER_____

Financial Information

Responsible Party to Pay_____ DOB:____/____/_____SS#:____/___/_____
Address:_____City/State/Zip:_____Phone #:_____
Employer:_____ Work #:_____ Relationship to Patient: _____

Insurance Information

Medicare ID #: _____ Arkansas Medicaid ID#:_____ Date Issued:____/____/____
Medicare Supplemental Insurance Company:_____ ID#:_____

Vision Insurance Company: _____ Member ID #:_____
Primary **MEDICAL** Insurance:_____ Member ID #:_____
Policy Holder's Name:_____ DOB:____/____/_____ Group #:_____
Policy Holder's Relationship to Patient:_____ Effective Date of Coverage:____/____/_____

Is this a workman's compensation claim?*(Circle)* Yes No Employer:_____
Name and Phone Number of Person to Verify claim_____

What is the primary reason for your visit today? Routine Exam Eye Problem(specify):_____
Other:_____

Patient Medical History

Medication Allergies (Please List):_____
Medications You Currently Are Taking (Please List):_____
_____
Major Surgeries/Hospitalizations (Please List Procedures and Dates): _____
_____

Have you ever been diagnosed with any of the following? *(Please Circle all that apply)*
Lazy Eye Prominent Eye Drooping Eyelid(s) Crossed Eye(s) Glaucoma
Retinal Disease Cataracts Eye Infection Eye Injury (Date of Injury)_____

Are you pregnant and/or nursing?[ ]Yes [ ]No
Do you currently wear glasses? [ ]Yes [ ]No If yes, how old is your present pair of lenses?_____
Do you wear contact lenses? [ ]Yes [ ]No If yes, how old is your present pair of lenses?_____
Type of contact lenses: [ ]Rigid/Gas Perm [ ]Dailies [ ]Extended Wear (Bi-Weekly or Monthly lenses) [ ]Other(Specify):_____
Are they comfortable? [ ]Yes [ ]No If no, please explain your discomfort:_____

PLEASE TURN THIS FORM OVER AND COMPLETE SIDE TWO

Family History

Please note any family history (parents, grandparents, siblings, or children) for the following conditions:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	[ ]	[ ]	[ ]	_____
Cataract	[ ]	[ ]	[ ]	_____
Crossed Eyes	[ ]	[ ]	[ ]	_____
Glaucoma	[ ]	[ ]	[ ]	_____
Macular Degeneration	[ ]	[ ]	[ ]	_____
Retinal Detachment /Disease	[ ]	[ ]	[ ]	_____
Arthritis	[ ]	[ ]	[ ]	_____
Cancer	[ ]	[ ]	[ ]	_____
High Blood Pressure	[ ]	[ ]	[ ]	_____
Lupus	[ ]	[ ]	[ ]	_____

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor.

[ ] Check here if you would prefer to discuss your social history directly with the doctor during your exam.

Do you have visual difficulty when driving? [ ]Yes [ ]No [ ]I Do Not Drive

If yes, please describe: _____

	NO	YES	
Do you use tobacco products?	**[ ]**	**[ ]**	If yes, type/amount and how long?_____
Do you drink alcohol?	**[ ]**	**[ ]**	If yes, type/amount and how long?_____
Do you use illegal drugs?	**[ ]**	**[ ]**	If yes, type/amount and how long?_____

Have you ever been exposed to or infected with: **[ ]**Gonorrhea **[ ]**Hepatitis **[ ]**HIV **[ ]**Syphillis

Review of Systems

Do You Currently, Or Have You Ever Had Any Problems In The Following Areas:

	NO	YES	?		NO	YES	?
Fever, Weight Loss/Gain	[ ]	[ ]	[ ]	***EARS, NOSE, MOUTH, THROAT***			
Integumentary (Skin)	[ ]	[ ]	[ ]	Allergies/Hay Fever	[ ]	[ ]	[ ]
Neurological	[ ]	[ ]	[ ]	Sinus Congestion	[ ]	[ ]	[ ]
Headaches	[ ]	[ ]	[ ]	Runny Nose	[ ]	[ ]	[ ]
Migraines	[ ]	[ ]	[ ]	Post-Nasal Drip	[ ]	[ ]	[ ]
Seizures	[ ]	[ ]	[ ]	Chronic Cough	[ ]	[ ]	[ ]
EYES				Dry Throat/Mouth	[ ]	[ ]	[ ]
Loss of Vision	[ ]	[ ]	[ ]	Respiratory	[ ]	[ ]	[ ]
Blurred Vision	[ ]	[ ]	[ ]	Asthma	[ ]	[ ]	[ ]
Distorted Vision	[ ]	[ ]	[ ]	Chronic Bronchitis	[ ]	[ ]	[ ]
Loss of Side Vision	[ ]	[ ]	[ ]	Emphysema	[ ]	[ ]	[ ]
Double Vision	[ ]	[ ]	[ ]	***VASCULAR/CARDIOVASCULAR***			
Dryness	[ ]	[ ]	[ ]	Diabetes	[ ]	[ ]	[ ]
Mucous Discharge	[ ]	[ ]	[ ]	High Blood Pressure	[ ]	[ ]	[ ]
Redness	[ ]	[ ]	[ ]	Vascular Disease	[ ]	[ ]	[ ]
Sandy/Gritty Feeling	[ ]	[ ]	[ ]	***ENDOCRINE***			
Itching	[ ]	[ ]	[ ]	Thyroid/Glandular Problems	[ ]	[ ]	[ ]
Burning	[ ]	[ ]	[ ]	***LYMPHATIC/HEMATOLOGIC***			
Foreign Body Sensation	[ ]	[ ]	[ ]	Anemia/Bleeding Problems	[ ]	[ ]	[ ]
Light Sensitivity	[ ]	[ ]	[ ]	***BONES/JOINTS/MUSCLES***			
Eye Pain or Soreness	[ ]	[ ]	[ ]	Rheumatoid Arthritis	[ ]	[ ]	[ ]
Chronic Infection of eye or lid	[ ]	[ ]	[ ]	Muscle Pain/Joint Pain	[ ]	[ ]	[ ]
Flashers/Floaters in Vision	[ ]	[ ]	[ ]	***PSYCHIATRIC***	[ ]	[ ]	[ ]
Tired Eyes	[ ]	[ ]	[ ]	***GASTROINTESTINAL PROBLEMS***	[ ]	[ ]	[ ]

Patient/Guardian Signature:_____ **Date:**_____

If Guardian, please print your name: _____

What is your relationship to the patient?:_____

I request that payment of authorized Medicare/Medicaid or other insurance benefits be made on my behalf to C. Michael Fletcher, O.D. for any services furnished to me at his office. I further authorize the release of information or medical records necessary to process these claims.

_____ _____

Signature Date

_____

Print Name