

ARMSTRONG COLT OPHTHALMOLOGY

PATIENT INFORMATION:

MR ___ MRS ___ MISS ___ MS ___ NAME _____
BIRTHDATE ___ / ___ / ___ AGE ___ male ___ female ___ SOCIAL SECURITY # _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
HOME PHONE _____ WORK PHONE _____ OCCUPATION _____
EMPLOYER NAME / ADDRESS _____
SPOUSE OR PARENTS NAME _____ FAMILY DR _____
WHO REFERRED YOU TO OUR PRACTICE? _____

INSURANCE INFORMATION

SUBSCRIBER NAME _____ SUBSCRIBER BIRTHDATE ___ / ___ / ___
SUBSCRIBER ADDRESS (IF DIFFERENT THAN ABOVE) _____
INSURANCE CO. NAME (S) _____

MEDICARE INSURANCE ONLY: PLEASE CIRCLE YES OR NO TO THESE 5 QUESTIONS:

- 1) Do you or your spouse work for a company that provides you with health insurance? YES or NO
- 2) Are you entitled to Medicare because of a disability or End Stage Renal Disease? YES or NO
- 3) Is this illness or injury related to an automobile accident or other injury? YES or NO
- 4) Has treatment for this accident or illness been authorized by the Veterans administration? YES or NO
- 5) Are you entitled to benefits under the Federal Black Lung Program? YES or NO

WE MUST HAVE YOUR PERMISSION TO BILL YOUR INSURANCE COMPANY FOR SERVICES RENDERED BY ARMSTRONG COLT OPHTHALMOLOGY. WE MUST HAVE YOUR SIGNATURE ON FILE. PLEASE SIGN THE STATEMENT BELOW. *SIGN YOUR NAME ON THE PATIENT SIGNATURE LINE ONLY*. WE ARE REQUIRED BY LAW TO HAVE YOUR SIGNATURE. IF YOU DO NOT SIGN THIS FORM, WE WILL BE UNABLE TO BILL YOUR INSURANCE COMPANY AND PROVIDE SERVICES FOR YOU TODAY. THANK YOU.

“ I AUTHORIZE ANY HOLDER OF MY MEDICAL INFORMATION BE RELEASED TO MY *MEDICARE* AND/OR *INSURANCE CARRIER* AND IT’S AGENTS -- FOR THE PURPOSE OF DETERMINING BENEFITS PAYABLE EITHER TO ME, OR TO THE PROVIDER WHO RENDERED MY SERVICES AT ARMSTRONG COLT OPHTHALMOLOGY. BY SIGNING THIS STATEMENT I AM GIVING MY PERMISSION TO BILL MY *MEDICARE* AND/OR OTHER *INSURANCE CARRIER*. I ALSO UNDERSTAND I WILL BE RESPONSIBLE FOR ANY OUTSTANDING BALANCES THAT ARE *NOT COVERED* BY MY INSURANCE CARRIER”.

PATIENT SIGNATURE _____ DATE _____

YEARLY UPDATES ONLY. - NOTE ANY NEW INSURANCE OR MEDICAL CHANGES YOU MAY HAVE, THAN WRITE YOUR INITIALS AND DATE.

INITIAL _____	DATE _____	CHANGES _____
INITIAL _____	DATE _____	CHANGES _____
INITIAL _____	DATE _____	CHANGES _____
INITIAL _____	DATE _____	CHANGES _____

REASON FOR VISIT : _____

MEDICATION ALLERGIES: _____

DAILY MEDICATIONS: _____

Patient past medical history (circle condition or circle no health problems)

ANXIETY	HEART ATTACK	SARCOID
ARTHRITIS	HEART MURMUR	SINUSITIS
ASTHMA	HEPATITIS	STROKE
BLEEDING DISORDER	HIGH BLOOD PRESSURE	THYROID DISORDER
BYPASS	IRREGULAR HEARTBEAT	SURGERIES _____
CANCER	LEUKEMIA	_____
DEPRESSION	LUPUS	OTHER: _____
DIABETES _____ YEARS	MULTIPLE SCLEROSIS	
EMPHYSEMA	NUMBNESS /TINGLING	NO HEALTH PROBLEMS

FAMILY HISTORY (circle all that apply)

BLINDNESS (REASON _____)

DIABETES

GLAUCOMA (WHO _____)

MACULAR DEGENERATION

RETINAL DETACHMENT

STROKE / NO HISTORY EYE DISEASE

SOCIAL HISTORY

DO YOU SMOKE yes or no (packs per day ____)

DO YOU DRINK ALCOHOL? Yes or no (amount _____)

OCULAR HISTORY OF PATIENT (circle all that apply to you or circle none)

AMBLYOPIA / BLINDNESS / CATARACTS / CATARACT SURGERY DONE / EYE INJURY /GLAUCOMA

IRITIS/ MACULAR DEGENERATION / RETINAL DETACHMENT /STRABISMUS

SURGERY DONE _____ / NO EYE PROBLEMS

REVIEW OF SYSTEMS (CIRCLE CONDITION YOU HAVE OR CIRCLE NONE)

(eyes) BLURRYVISION / DISTORTED OR WAVY VISION / DOUBLE VISION / DRYNESS / FLASHES / FLOATERS / GLARE // HALOS / ITCHING / IRRITATION / LOSS OF VISION / PAIN IN OR AROUND EYE / REDNESS / TEARING / OTHER _____ / NONE

(constitutional) FEVER / WEIGHT LOSS / WEIGHT GAIN / NONE

(ears,nose,throat) COUGH / HEARING LOSS / JAW PAIN / RUNNY NOSE / SCALP TENDERNESS / SINUS PROBLEMS / SORE THROAT / NONE

(respiratory) ASTHMA / EMPHYSEMA / SHORTNESS OF BREATH / NONE

(cardiovascular) CHEST PAIN / HEART ATTACK / HIGH BLOOD PRESSURE / NONE

(gastrointestinal) HERNIA / HEPATITIS __ / JAUNDICE / ULCER _____ / NONE

(genitourinary) CANCER- OVARIAN, UTERINE, PROSTATE / KIDNEY DISEASE / NONE

(integumentary) BREAST DISEASE OR CANCER / SKIN DISEASE OR CANCER / NONE

(musculoskeletal) ARTHRITIS _____ / CANCER _____ / JOINT PAIN / NONE

(endocrine) DIABETES _____ YEARS (INSULIN? Yes or no) THYROID DISEASE / NONE

(hematologic/lymphatic) BLOOD DISORDER / CANCER _____ / LEUKEMIA / NONE

(neuro/psychiatric) AGITATION / ANXIETY / DEPRESSION /STROKE / OTHER _____ /NONE

(immunologic/allergic) IMMUNE SYSTEM DISEASE / LUPUS / OTHER _____ / NONE

SEASONAL ALLERGIES / OTHER ALLERGIES _____ /NONE