HEALTH INFORMATION

PATIENT LAST NAME: ___________________________ **FIRST NAME:** ________________________

Date of last eye exam: ____________With whom? ___________

All Patients:
Describe any eye concerns/problems that bring you to our office today: ________________________________

Describe any changes concerns about your eyes/vision since your last eye exam: _______________________________
____

ALLERGIES: ☐ **NONE or** Specify _____________________

DO YOUWEAR:	Currently Wear	Wore in the Past	For Reading	For Distance	Cosmetic/Prostheses
Glasses ?	☐ YES ☐ NO	☐ YES ☐ NO	☐YES ☐ NO	☐ YES ☐NO	-------------------------
Contacts ?	☐ YES ☐ NO	☐ YES ☐ NO	☐YES ☐NO	☐YES ☐NO	☐ YES ☐ NO

DO YOU SMOKE? ☐ **Yes #cigs/day____** ☐ **No** **Use other tobacco products? (explain)_______________**

☐ **Quit: ___# months ago or ____ # years ago**

Current Medications you are taking: ☐ **Oral contraceptives** ☐ **Aspirin** ☐ **Medications for pain or arthritis**

☐ **EYE DROPS:** ____

☐ **Other Medications?** Please complete the attached Medication List Assessment Form

Please **CHECK below: yes or no** to **any medical conditions you or your immediate family** members currently have or *have ever had*.
Please note the relationship of the family member for any noted family conditions:
Mother=M Father =F Sibling =S

	YOU		FAMILY			YOU		FAMILY	
EYE CONDITIONS:	YES	NO	YES	NO		YES	NO	YES	NO
Cataract (s)					Cancer				
Blurred/Fuzzy Vision					Diabetes:				
Cosmetic or Reconstructive Eye Procedures					On Insulin?				
					Gastric/Stomach Disorders				
Double Vision					Hard of HEARING				
Dry Eye (s)					Kidney Disorders				
Eye Infection					Headaches				
Eye Injury					High Blood Pressure				
Eye Surgery: DATE______					Heart Attack: DATE:_____				
Eye Tearing					Heart Stent(s):DATE:______				
Glaucoma					Other Heart Condition(s):				
Macular Degeneration					Lung Disorders:				
Retinal Problems					Pregnant: currently?				
Spots/Floaters					Seizure Disorders				
Visual Halos					Other Neurological:				
Other eye disorder:					Sinus Infections				
Medical History:					Skin Disorders				
Allergies/Hay Fever					Major Surgery: Explain Below				
Asthma					Thyroid Disorders				
Bleeding or Blood Disorders					Urinary Disorders				

***Explain any boxes checked "yes":** ____

PATIENT (or responsible person) Signature: ______________________ **Print Name (If different from patient):**______________

EYE GROUP OF CONNECTICUT, LLC

Jeffrey N. Kaplan, MD · Jeffrey R. Sandler, MD

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WELCOME TO OUR OFFICE ***PLEASE PRINT CLEARLY***

PATIENT LAST NAME: ______________________ **PATIENT FIRST NAME:**______________________
Nickname/Preferred Name: __________________ ☐Mr ☐Mrs ☐Miss ☐Ms ☐Dr ☐OTHER______

☐Single ☐Married ☐Widowed ☐Minor Child Your relation to Minor Child: ___________________________
☐Student ☐Retired ☐Unemployed ☐Actively employed: **Occupation:** _________________________________

Patient Sex: ☐Male ☐Female **Patient DATE OF BIRTH:** ___/___/____ **S.S.#**__________________
Primary Language: ☐English ☐Other: _________

Who referred you to our office? ☐ Self-referral ☐ MD ☐Other/Name: ___________________________

NAME OF PRIMARY CARE DOCTOR: ____

PATIENT HOME ADDRESS:

Street:________________________
City/Town________________ State:____
ZIP:__________

PATIENT BILLING ADDRESS: ☐*SAME AS HOME*

Street:_____________________
City/Town________________ State:___
ZIP:______

HOME PHONE: (____) ________________

CELL PHONE: (_____) _______________
E: MAIL Address: _____________________

EMERGENCY CONTACT:

☐Use **home phone** number provided ☐Use **cell phone** number provided
☐OTHER phone: ___________________**NAME:** ___________________________**Relation to patient:** ______________
May we discuss all personal health information with this contact person? ☐**Yes** ☐**NO**

HOW WOULD YOU PREFERTO BE CONTACTED **FOR FUTURE APPOINTMENT REMINDERS?**

☐Use **home phone** number provided ☐Use **cell phone** number ☐Texting allowed
☐Other: (__) _________________________ Is this a work number? ☐Yes ☐NO

FINANCIAL RESPONSIBILITY: ***** *pertains to the person who is financially responsible for this visit*******

Policy Holder LAST Name: ______________________ **FIRST Name:** ______________________________
☐**SELF** ☐**Spouse** ☐**Parent** Date Of Birth **of Policy Holder:** ____/______/_____

Phone Number: (____) ________________________________ ☐**Cell** ☐**Home**

Patient/Guarantor employment:
Name of Employer: ________________________ Address of Employer: __________________________
Employer Phone: _________________________ __________________________

Primary INSURANCE CARRIER NAME: _________________________ **Effective date**_____

Secondary INSURANCE CARRIER ☐**NONE** ______________________ **Effective date**________

Please present your insurance card (also photo ID for all new patients only) to our front reception staff

YOUR PHARMACY Name and Address (**street and town**):____
____

SIGNATURE OF PATIENT (Guarantor): ____________________ **Date:**______
My signature here attests the information provided **on both sides** of this form to be true and correct