

PATIENT MEDICAL HISTORY RECORD

Acct #

DATE (MM/DD/YY)	REFERRED BY	BIRTH DATE
PATIENT'S NAME		SEX AGE
ADDRESS		PHONE (H)
EMPLOYER	OCCUPATION	PHONE (W)
SOC SEC NO.		PRIMARY CARE PHYSICIAN

Please answer the following questions about your medical status and history:

1. Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, arthritis, etc)?
Yes No If YES, please explain: _____
2. Have you ever had any eye disease (e.g., glaucoma, cataract, wandering or "lazy" eye, retinal detachment)?
Yes No If YES, please explain: _____
3. Have you ever had any surgery?
Yes No If YES, please provide date and reason _____
4. Have you ever been hospitalized?
Yes No If YES, please provide date and reason _____
5. Do you take any medications?
Yes No If YES, please list: _____
Do you take any eye medications: _____
Yes No If YES, please list: _____
6. Do you have any drug or food allergies?
Yes No If YES, please list: _____

Review of Systems

	Yes	No	If YES, please explain:
Do you currently have any of the follow problems?			
Chronic fever, unexpected weight loss/gain, fatigue	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear/nose/throat problems (e.g., hearing loss, sinus problems, sore throat)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart problems (e.g. chest pain, irregular heart beat).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory problems (e.g., shortness of breath, wheezing, coughing).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea, vomiting)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinal problems (e.g. pain or discomfort, blood in urine)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin problems (e.g. rashes, excessive dryness).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal problems (e.g., muscle aches, joint pain, swollen joints)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurologic problems (e.g., numbness, weakness, headaches, paralysis)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric problems (e.g., depression, anxiety).....	<input type="checkbox"/>	<input type="checkbox"/>	_____

Family and Social History

Do any medical or eye diseases run in your family (e.g., diabetes, high blood pressure, cancer, glaucoma, macular degeneration)?
Yes No If YES, please explain: _____

Do you smoke? If YES, how much? Drink alcohol? If YES, how much?

If employed, how many hours per week do you work?

Comments _____

Signature _____ Date _____

Patient Information

PERSONAL INFORMATION (Please Print)

ACCT# _____

Name _____ Date _____

Date of Birth _____ Age _____ M / F _____ Soc Security # _____

Address _____

Phone: Home (____) _____ Street _____ Work (____) _____ City _____ State _____ Zip _____

Occupation _____ Employer _____

Address _____ Phone (____) _____

Marital Status: Single Married Widowed Divorced

Spouse Name _____ Employer _____

Address _____ Phone (____) _____

Referred by : Friend/Relative _____ Doctor _____ Yellow Pages Radio Other _____
Name Name

Complete if under 18 years or a student

Name of Father _____ Employer _____

Address _____ Phone (____) _____

Name of Mother _____ Employer _____

Address _____ Phone (____) _____

INSURANCE INFORMATION

 Medicare # _____ Medicaid # _____ Other Medical Insurance _____

Group # _____ ID# _____

Name/Address 2nd Insurance _____

Are you personally responsible for the payment of your fees? Yes No If not, who is?

Name _____ Relationship _____ DOB _____

Who to notify in emergency (nearest relative or friend)?

Name _____ Relationship _____

Address _____

Street _____ City _____ State _____ Zip _____

Home Phone (____) _____ Work Phone (____) _____

AUTHORIZATION FOR TREATMENT AND FINANCIAL ASSIGNMENT AND AGREEMENT:

1. I hereby voluntarily consent to medical care for the above named patient, diagnostic procedures and medical treatment by physician, his/her assistants or designees as may be necessary in his/her judgement. I acknowledge that no guarantees have been made as to the results of treatment or examination.
2. In order to control your cost of billings, we request that your deductibles and co-pays for office visits be paid at the conclusion of each visit.
3. I hereby assign to Harrisburg Eye Clinic all rights, title and interest in the benefits payable to me by an insurance policy (ies) or benefits plan under which I am covered for services rendered by the physician. I understand that I am responsible for all charges not covered by this assignment and hereby promise to pay any remaining balance.
4. I authorize Harrisburg Eye Clinic to release to the insurance carrier, Social Security Administration, third party administrators, or any party that may be liable for all or part of medical charges, information as may be necessary for the purpose of enabling the determination of benefits available to the patient for the services rendered during this period of care.

Signed (Patient or parent if minor) _____ Date _____