

BRUCE L. HAMMONDS, O.D., P.C.

PATIENT INFORMATION

Male Female

Name _____ Birth Date ____ / ____ / ____ Soc. Security # _____

Address _____ Home Phone: _____

City _____ State _____ Zip _____ Pager or Cell # _____

Your School _____ Grade _____

Father's Name _____ Birth Date ____ / ____ / ____ Soc. Security # _____

Father's Employer _____ Work Phone # _____

Mother's Name _____ Birth Date ____ / ____ / ____ Soc. Security # _____

Mother's Employer _____ Work Phone # _____

Last Eye Exam ____ / ____ Name of Doctor _____

Whom may we thank for referring you to our office? _____

Nearest Relative (not living with you)

Name _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

Insurance Information (Primary)

Name of Insured _____ Relationship to Patient _____

Insured's Date of Birth _____ Insurance Company _____

DO YOU HAVE ADDITIONAL INSURANCE(SECONDARY)? NO YES

Responsible Party

Name of person responsible for this account? _____

Relationship to patient _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eye care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor or ophthalmic group insurance benefits otherwise payable to me. I understand that my eye care insurance carrier may pay less than the actual bill for services. I agree to be responsible for payments of all services on my behalf or my dependents.

X _____

Date _____

SIGNATURE OF PATIENT (PARENT)

Patient: _____ Date: _____

REVIEW OF HEALTH SYSTEMS ◆ (ROS)

◆ **EYES** Have you had or do you have any of the following?

Glaucoma:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do You Wear Glasses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do You Wear Contacts?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dry Eyes:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do You Drive?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other eye problems:	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Please describe any problems with the following health systems:

◆ GASTROINTESTINAL <input type="checkbox"/> No Problem <input type="checkbox"/> Ulcer <input type="checkbox"/> Colitis <input type="checkbox"/> Reflux <input type="checkbox"/> Diarrhea <input type="checkbox"/> Heartburn	◆ NEUROLOGICAL <input type="checkbox"/> No Problem <input type="checkbox"/> Epilepsy <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Headaches <input type="checkbox"/> Numbness
◆ EARS/NOSE/THROAT <input type="checkbox"/> No Problem <input type="checkbox"/> Upper Respiratory Infection <input type="checkbox"/> Sinusitis <input type="checkbox"/> Chronic Colds	◆ CONSTITUTIONAL <input type="checkbox"/> No Problem <input type="checkbox"/> Fever <input type="checkbox"/> Weight Loss <input type="checkbox"/> Fatigue <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Trauma
◆ CARDIOVASCULAR <input type="checkbox"/> No Problem <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Stroke <input type="checkbox"/> Vascular Disease <input type="checkbox"/> Chest Pain <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Heart Disease	◆ MUSCULOSKELETAL <input type="checkbox"/> No Problem <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Joint Pain <input type="checkbox"/> Muscle Ache
◆ RESPIRATORY <input type="checkbox"/> No Problem <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> Wheezing <input type="checkbox"/> Coughing	◆ INTEGUMENTARY <input type="checkbox"/> No Problem <input type="checkbox"/> Psoriasis <input type="checkbox"/> Eczema <input type="checkbox"/> Rashes <input type="checkbox"/> Acne <input type="checkbox"/> Excessive Dryness <input type="checkbox"/> Cancer
◆ ALLERGIC/IMMUNE <input type="checkbox"/> No Problem <input type="checkbox"/> Allergies _____ <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Lupus <input type="checkbox"/> HIV	◆ ENDOCRINE <input type="checkbox"/> No Problem <input type="checkbox"/> Thyroid Dysfunction <input type="checkbox"/> Hormonal Dysfunction <input type="checkbox"/> Type 1 Diabetes <input type="checkbox"/> Type 2 Diabetes
◆ BLOOD/LYMPH <input type="checkbox"/> No Problem <input type="checkbox"/> Anemia <input type="checkbox"/> Leukemia	◆ PSYCHIATRIC (MENTAL) <input type="checkbox"/> No Problem <input type="checkbox"/> Depression <input type="checkbox"/> Bipolar <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Anxiety
◆ GENITOURINARY <input type="checkbox"/> No Problem <input type="checkbox"/> STD <input type="checkbox"/> Bladder Infection <input type="checkbox"/> Blood in Urine	

PAST, FAMILY, & SOCIAL HISTORY ★ (PFSH)

★ **PATIENT PAST HISTORY**

Have you had any eye operations? Yes No Date: _____ Type: _____

Have you had an eye injury? Yes No Date: _____ Type: _____

Have you had a retina detachment? Yes No Date: _____ Type: _____

Name of family doctor: _____

★ SOCIAL HISTORY Do you use alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No Amount: _____ Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No Amount: _____ Do you use other substances? <input type="checkbox"/> Yes <input type="checkbox"/> No What: _____ Describe any special visual needs: _____	Are You: <input type="checkbox"/> Pregnant <input type="checkbox"/> Nursing	List Drug Allergies: _____ _____ _____
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★ **Family History** Do any family members have any of the following problems:

High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No Relationship _____	Macular Degeneration <input type="checkbox"/> Yes <input type="checkbox"/> No Relationship _____
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No Relationship _____	Retinal Detachment <input type="checkbox"/> Yes <input type="checkbox"/> No Relationship _____
Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No Relationship _____	Cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No Relationship _____
Other eye condition <input type="checkbox"/> Yes <input type="checkbox"/> No Relationship _____	Description: _____

Patient Signature: _____ Date Reviewed _____ Changes _____ <input type="checkbox"/> No Changes _____ <input type="checkbox"/> No Changes _____ <input type="checkbox"/> No Changes _____ <input type="checkbox"/> No Changes _____	List all medications:(oral, drops, patches, etc...) _____ _____ _____ _____ _____
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