PELHAM
EYE CENTER

**Patient Information**

Name: _____ Date: _____
First MI Last

Address _____ City _____ State_____ Zip_____

Date of Birth _____ Best Phone # _____ Alternate Phone _____
Indicate: Mobile / Home / Work

Employer/School_____ Occupation/Grade_____

Spouse/Parent Name (if minor)_____

Email Address_____

**Insurance Information**

Full Name of Person Insured_____ Relationship to Patient_____

Date of Birth of Person Insured _____Member ID_____

Employer of Insured_____ Name of Insurance Co_____ Group #_____

**Health History**

Reason for today's eye exam _____

Date of last eye exam _____ Name of last eye doctor _____

Date of last physical exam _____ Name of primary physician _____

Do you or anyone in your immediate family (mother, father, siblings) have or have a history of the following:

_____ Diabetes _____High blood pressure _____ High cholesterol _____Heart disease _____ Thyroid disease

_____ Glaucoma _____ Macular degeneration _____ Turned eye/lazy eye _____ Blindness

Other:_____

**Please check any of the following that apply to YOU:**

_____ Respiratory condition _____ Skin condition _____Musculoskeletal condition _____ Neurological condition

_____Gastrointestinal condition _____ Ear/Nose/Throat _____ Blood disorders _____ Allergies _____ Other

_____ Pregnant/nursing _____ Eye injury _____ Eye pain _____ Headaches

_____ Eye surgeries, list: _____

_____ Drug allergies, list: _____

List all medications: _____

_____ Tobacco (if yes, how much): _____ _____ Alcohol (if yes, how much)? _____

Do you wear: _____ Glasses? _____ Contacts? _____ Brand _____ Are you interested in contacts? _____

**Authorization**

I certify that I have completed the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release information (including diagnosis and treatment) rendered to me or my child to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor 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 payment of all services rendered on my behalf or my dependents' behalf.

_____

**Signature of patient (or parent if a minor)** **Date**