# KINNELON EYECARE

## PATIENT INFORMATION FORM

**DATE:** _____

**LAST NAME:** _____ **FIRST NAME:** _____ **DOB:** _____

**ADDRESS:** _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

**HOME PHONE:** _____ **CELL PHONE:** _____ **DAY PHONE:** _____

**SOCIAL SECURITY#:** _____ **EMPLOYER NAME:** _____

**EMAIL:**_____ **GENDER:** __M __F __O

**PRIMARY MEDICAL INSURANCE:** _____

**PRIMARY MEDICAL INSURANCE ID #:**_____

**PRIMARY INSURED NAME:** _____

**PRIMARY INSURED SS#:** _____ **PRIMARY INSURED DOB:** _____

**PRIMARY VISION INSURANCE:** _____

**PRIMARY VISION INSURANCE ID #:** _____

**PRIMARY VISION INSURED NAME:** _____

**PRIMARY VISION INSURED SS#:** _____ **PRIMARY VISION INSURED DOB:** _____

**SECONDARY MEDICAL INSURANCE:** _____

**SECONDARY MEDICAL INSURANCE ID #:** _____

**SECONDARY INSURED NAME:** _____

**SECONDARY INSURED SS#:** _____ **SECONDARY INSURED DOB:** _____

**SECONDARY VISION INSURANCE:** _____

**SECONDARY VISION INSURANCE ID #:** _____

**SECONDARY VISION INSURED NAME:** _____

**SECONDARY VISION INSURED SS#:** _____ **SECONDARY VISION INSURED DOB:** _____

RACE: ◯ DECLINED TO SPECIFY ◯ AMER. INDIAN/ ALASKA NATIVE ◯ ASIAN ◯ BLACK OR AFRICAN AMERICAN ◯ WHITE

ETHNICITY: ◯ HISPANIC OR LATINO ◯ NOT HISPANIC / LATINO ◯ DECLINED TO SPECIFY

PREFERRED LANGUAGE: ◯ ENGLISH ◯ SPANISH ◯ OTHER _____ ◯ DECLINE TO SPECIFY

PREFERRED COMMUNICATION: ◯ PHONE ◯ MAIL ◯ TEXT: ☒ APPT NOTIFICATIONS ☒ ORDER NOTIFICATIONS ◯ EMAIL ☒ RECALLS ☒ PROMOTIONS

REFERRED BY: ◯ ANOTHER PATIENT ◯ INSURANCE ◯ PROFESSIONAL ◯ WALK IN ◯ NON REFERRAL ◯ NONE

**PHARMACY INFO**

NAME: _____ ZIPCODE: _____

ADDRESS: _____ PHONE: _____

**MEDICAL HISTORY**
Do you have or have you had

◯ NONE ◯ Arthritis ◯ Hypertension (High Blood Pressure) ◯ Hyperthyroidism

◯ Asthma ◯ Hypercholesterolemia (Cholesterol) ◯ Hypothyroidism

◯ Diabetes Type 1 or 2 ◯ Stroke ◯ Other_____

◯ Cancer - type: _____

*PAST SURGERY*: _____ DATE: _____

**OCULAR HISTORY**
Do you have or have you had

◯ NONE ◯ Cataract R / L ◯ Glaucoma R / L ◯ Strabismus (Eye Turn)

◯ Contacts ◯ Macular Degeneration R / L ◯ Other Eye Condition:_____

◯ Glasses ◯ Retinal Tear R / L _____

*PAST EYE SURGERY*: _____ DATE: _____

**CURRENT MEDICATIONS**

◯ NONE

◯ SEE SCANNED LIST

NAMES & DOSAGES OF MEDICATIONS

_____ _____

_____ _____

_____

**ALLERGIES**

TO MEDICATIONS: ◯ NONE NAME OF MEDICATIONS: REACTION:

_____ _____

_____ _____

OTHER ALLERGIES: ◯ NONE ALLERGY ITEMS: REACTION:

_____ _____

_____ _____

**SOCIAL HISTORY**

SMOKING ◯ NEVER ◯ FORMER SMOKER ◯ CURRENT, EVERY DAY ◯ CURRENT SOME DAYS

ALCOHOL ◯ NEVER ◯ LESS THAN 1 DRINK / DAY ◯ 1-2 DRINKS / DAY ◯ 3 OR MORE DRINKS/DAY

**FAMILY HISTORY**

◯ Macular Degeneration / Relation: _____ ◯ Coronary Artery Disease / Relation: _____ Relation:_____

◯ Glaucoma / Relation: _____ ◯ Stroke / Relation: _____ ◯ No Family History

◯ Retinal Detachment / Relation: _____ ◯ Diabetes Type 1 or 2 / Relation:_____ ◯ Atrial Fibrillation/ Irregular Heartbeat

◯ CANCER: Type: _____ Relation: _____ Type: _____ Relation: _____

**REVIEW OF SYSTEMS**
ARE YOU EXPERIENCING

◯ Poor Vision ◯ Tearing ◯ Seeing Floaters ◯ Congestion ◯ Headaches

◯ Double Vision ◯ Eye Redness ◯ Weight Loss ◯ Shortness ofBreath ◯ Other:

◯ Eye Pain ◯ See Flashing Lights ◯ Rapid Heartbeat ◯ Dry Mouth _____