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:** _____

PRIMARY MEDICAL INSURANCE: _____

PRIMARY INSURED NAME: _____

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

PRIMARY VISION INSURANCE: _____

PRIMARY VISION INSURED NAME: _____

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

SECONDARY MEDICAL INSURANCE: _____

SECONDARY INSURED NAME: _____

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

SECONDARY VISION INSURANCE: _____

SECONDARY VISION INSURED NAME: _____

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

KINNELON EYECARE

PLEASE PRINT CLEARLY

NAME: _____ DOB: _____

EMAIL: _____ GENDER: __M __F __O

RACE: ◯ BLACK/AFRICAN AMERICAN ◯ AMER. INDIAN/ALASKA NATIVE ◯ ASIAN ◯ NAT. HAWAIIAN / PACIFIC ISLAND ◯ WHITE ◯ DECLINE TO SPECIFY

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
◯ Asthma
◯ Diabetes Type 1 or 2
◯ Hypertension (High Blood Pressure)
◯ Hypercholesterolemia (Cholesterol)
◯ Stroke
◯ Hyperthyroidism
◯ Hypothyroidism
◯ Other_____

◯ Cancer - type: _____

PAST SURGERY: _____ DATE: _____

OCULAR HISTORY
Do you have or have you had

◯ NONE
◯ Cataract R / L
◯ Contacts
◯ Glasses
◯ Glaucoma R / L
◯ Macular Degeneration R / L
◯ Retinal Tear R / L
◯ Strabismus (Eye Turn)
◯ Other Eye Condition:_____
_____

PAST EYE SURGERY: _____ DATE: _____

CURRENT MEDICATIONS

◯ NONE
◯ SEE SCANNED LIST

NAMES 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: _____
◯ Glaucoma / Relation: _____
◯ Retinal Detachment / Relation: _____
◯ CANCER: Type: _____
◯ Diabetes Type 1 or 2 / Relation:_____
◯ Coronary Artery Disease / Relation: _____
◯ Stroke / Relation: _____
Relation: _____ Type: _____ Relation: _____
◯ Atrial Fibrillation/ Irregular Heartbeat
Relation:_____
◯ No Family History

REVIEW OF SYSTEMS
ARE YOU EXPERIENCING

◯ Poor Vision
◯ Double Vision
◯ Eye Pain
◯ Tearing
◯ Eye Redness
◯ See Flashing Lights
◯ Seeing Floaters
◯ Weight Loss
◯ Rapid Heartbeat
◯ Congestion
◯ Shortness of Breath
◯ Dry Mouth
◯ Headaches
◯ Other:
_____