Patient Demographics and Medical History Record

Please print and complete form in its entirety:

Today's Date___________________________ Patient's Age _______ M or F __________

Last Name _____________________________ First Name ___________________________MI___

Birth Date____________________________ SSN# _____- _______ - _______

Home Address ___________________________ City______________ State____ Zip Code_________

Home Phone ____________________Work Phone__________________ Cell Phone: ________________

Employer _____________________ Occupation ______________________________

Marital Status (S/M/D/W): _____ Spouse ________________ Spouse Phone# _______________

Emergency Contact _________________ Phone Number ___________________________

Date of Last Eye Exam ________________ Dilated? (Please circle) Yes or No

Name of Primary Care Doctor_______________________________

Name of Previous Eye Doctor ______________________Referred by: _____________________

Medical Insurance Information: Doctor would like information written below.

Name of Carrier: ________________________ ID#_________________________________

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Vision Insurance Information: **(VSP and EYEMED patients ONLY)**

Name of Carrier: __________________Last 4 digits of main ***VSP*** subscriber's SSN# (if different from patient) ________

Name and Birth Date of main ***VSP/EYEMED*** subscriber: _____________________________________

If someone other than the patient is responsible for payment please complete below.

Name: __________________________________Employer: ________________________

Address: ________________________________Work Phone: _______________________

Phone: _________________________________ Social Security: ____________________

Doctor Use Only

Reviewed by ____________________ **No changes** ☐ **Date** ______________________

Reviewed by ____________________ **No changes** ☐ **Date** ______________________

Reviewed by ____________________ **No changes** ☐ **Date** ______________________

Bruce I. Kirschner, M.D. Shirley Fong, O.D.

Circle if you have or have had any of the following conditions?

Eye Problem/Infections	High blood pressure	Wear glasses
Eye surgery	Diabetes: type & date of diagnosis	Wear contact lenses
Eye injury	Skin condition/rash	Excess tearing/ watering
Loss of vision	Muscles/Bones	Mucous discharge
Blurred/Distorted vision	Psychiatric	Glare/light sensitivity
Double vision	Droopy Eyelid	Eye pain/soreness
Dryness	Joint pain	Chronic eyelid infection
Redness	Diarrhea/Constipation	Allergies/Hay fever
Itching	Blood/Lymph	Sinus Congestion
Burning	HIV	Dry Throat
Bulging eyes	Do you use any eye drops?	Asthma
Glaucoma	Retinal problems	Autoimmune
Macular degeneration	Crossed eye/lazy eye	Emphysema/Bronchitis
Cataract	Headaches	Chest pain
Irregular heart beat	Stomach pain	Other health problems
Do you/did you smoke? How much?	Interested in learning about laser eye correction	When did you have your last tetanus shot?
Do you take prescription or over the counter medications? List name & dosage	Any allergic reactions to medications or other substances? If yes, list which ones and type of reaction	Any recent changes in health status? Ex: pregnancy, surgery etc…

If you checked yes to any of the above, please explain in further detail. Again, please list all prescription or over the counter medications you may take: ______________________________

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Do you have a **FAMILY HISTORY** (blood relatives) of any of the following? **If yes, please state the relationship**.

	Relationship		Relationship
Diabetes		Glaucoma	
High blood pressure		Macular Degeneration	
Retinal Detachment		Cataracts	

Please sign below that you have reviewed all the information above and it is correct to the best of your knowledge. As a patient or legal guardian of a minor patient, you agree to pay for all services rendered. This office may bill your insurance carrier as needed. Your signature below will also signify that all insurance benefits be paid directly to Dr. Kirschner. You are financially responsible for all non-covered services. You authorize the physician to release any information necessary to process this request. **Should you wish someone in addition to yourself to have full access to your medical information and speak on your behalf, please print their name, relationship and phone number below your signature.**

Signature ______________________ **Date** ______________________

Name of person that is allowed to act on your behalf:

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