NORTHWEST OPHTHALMOLOGY CENTER, INC.
PATIENT INFORMATION

PATIENT INFORMATION ***PLEASE PRINT*** **Gender**: Male Female **Marital Status**: S M D W

Patient Name: ____________________________ _________ ______________________________________
FIRST MI LAST

Address ____ Apt .__________ Home Phone _______-______-___________

City, State, Zip Code____Cell Phone: _______-______-___________

Social Security No. ______-_____-______ Birthdate ______/________/______ Work Phone: _______-______-___________

E-Mail Address____ Occupation_____________________________ FT PT

Patient Employer ____________________________________Employer Address_______________________________________

Who may we thank for referring you to our office?_________________ _______________________________________

How would you prefer to be reminded about upcoming appointments in the future? Check all that apply:

Text Message Email Home Phone

SPOUSE INFORMATION (OR GUARANTOR IF PATIENT IS MINOR) ***PLEASE PRINT***

Name ____ Birthdate ____/_____/____ Social Security No______-______-_________

Employer____ Employer Phone: _______________________________________

Employer Street Address _________________________________ City, State, Zip_____________________________________

EMERGENCY CONTACT (OTHER THAN SPOUSE) ***PLEASE PRINT***

Name____ Phone Number _______________________________

Relationship to Patient ______________________________________

INSURANCE INFORMATION: ***RECEPTIONIST WILL COPY ALL INSURANCE CARDS***

PRIMARY

Name of Insurance Co.**.**_____________________________________ Name of Policy Holder ____________________________

Policy #_______________________________ Group # _______________________ Relationship to Patient________________

Birthdate of Policy Holder________/_________/_______

SECONDARY

Name of Insurance Co._____________________________________ Name of Policy Holder ____________________________

Policy # Group # Relationship to Patient

PATIENT MEDICAL HISTORY

NAME:____ BIRTHDATE:_____/_____/_______ SEX: M F

Do you have a family doctor? Yes or No If yes, please list ____

REVIEW OF SYSTEMS

Please mark the box if you have any of the following:

Fever	Hypertension	Shortness of Breath	Diarrhea	Muscle Aches/Joint Pain
Hearing Loss	Heart Problems	Wheezing	Vomiting	Arthritis
Sinus Problems	Chest Pain	Cough	Abdominal Pain	Cancer
Sore Throat	Irregular Heartbeat	Asthma	Rashes	Diabetes
Anxiety/Depression	Stroke/TIAs	Urinary Problems	Dry Skin	Blood Disorders

Other, please specify:

Explain any problems checked above:

Family History:

Do any medical or eye diseases run in your family? Please check Yes or No If yes, please check all that apply:

GLAUCOMA MACULAR DEGENERATION HYPERTENSION HEART DISEASE CANCER DIABETES

OTHER ____

Social History:

Do you smoke? (Check One) Y N If, yes, how much?_______________

Do you drink alcohol? (Check One) Y N If , yes, how much?______________

List ALL medications (including eye medications) you are currently taking. Please include prescription and over-the-counter medications: (**We will be happy to copy your list if you have one**)

List Any/All Eye Surgeries/Diseases/Traumas you have had:

List All Surgeries (excluding eye):____

List All Allergies (Food and/or Drug):____

Are you allergic to Latex or Adhesive Tape ? Check One Y N

Signature: Date / /