



Hazleton Eye Specialists Stroudsburg Eye Specialists

PATIENT INFORMATION FORM

Please print/complete and bring in at your appointment

First Name _____ Last Name _____ Middle Initial _____
Date of Birth _____ Age _____ Sex _____ Marital Status (circle one) Married / Single
Street Address _____ State _____ Zip _____
Home Phone # _____ Cell Phone # _____ Work Phone # _____
Email address: _____

Referred by (please circle one): Internet, Newspaper, Commercial / TV, Phone book, Doctor (name)

_____, Friend (name) _____

Employment

Employment Status (circle one): Employed / Self Employed / Not Working Occupation: _____
Employer _____ Employer Phone # _____
Employer Address _____ State _____ Zip _____

Other Contact Information

Person Responsible for Charges? (if not patient) _____ Relationship to Patient _____
Home Phone # _____

Emergency Contact Information

Who should we contact in case of an emergency? _____ Relationship to Patient _____
Home Phone # _____ Cell Phone # _____ Work Phone # _____

Eye-Health- Patient (check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Amblyopia | <input type="checkbox"/> Eye Surgeries | <input type="checkbox"/> Itchy Feeling |
| <input type="checkbox"/> Blurred Vision Far | <input type="checkbox"/> Eye Turn | <input type="checkbox"/> Infection of Eye / Lid |
| <input type="checkbox"/> Blurred Vision – Near | <input type="checkbox"/> Floaters / Spots | <input type="checkbox"/> Loss of Vision – Central |
| <input type="checkbox"/> Burning Eyes | <input type="checkbox"/> Fluctuating Vision | <input type="checkbox"/> Loss of Vision – Side |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Foreign Body Sensation | <input type="checkbox"/> Mucus / Discharge |
| <input type="checkbox"/> Double / Distorted Vision | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Redness |
| <input type="checkbox"/> Drooping Eyelid | <input type="checkbox"/> Glare / Light Sensitivity | <input type="checkbox"/> Retinal Detachment |
| <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Headaches | <input type="checkbox"/> Tearing / Watery Eyes |

General-Health- Patient (check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Allergies / Hay fever | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Asthma / Respiratory | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Psychiatric / Depression |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gastrointestinal Problems | <input type="checkbox"/> Thyroid/ Endocrine Disease |
| <input type="checkbox"/> Cardiovascular/ High B.P | <input type="checkbox"/> Heart Attack / Stroke | <input type="checkbox"/> Skin Disorders |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Headaches / Migraines | <input type="checkbox"/> Weight Loss / Gain |

Family History- Blood Relatives (check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Amblyopia (Lazy Eye) | <input type="checkbox"/> Color Blindness | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Eye Turn | <input type="checkbox"/> Retinal Detachment |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Stroke / Heart Attack |
| <input type="checkbox"/> Cataract(s) | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disease |

Name of Family Physician _____ Physician's Phone Number _____

Medications/Vitamins/Supplements – Enter all medications/Vitamins/Supplements taken by the patient and for what condition each is taken for.

| Medication/Vitamins/Supplements | Condition |
|--|------------------|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |
| 4. _____ | _____ |
| 5. _____ | _____ |
| 6. _____ | _____ |
| 7. _____ | _____ |
| 8. _____ | _____ |
| 9. _____ | _____ |
| 10. _____ | _____ |

Please answer the following Questions:

1. Are you Pregnant or Nursing? Yes / No
 2. Do you have trouble driving at night? Yes / No
 3. Do you wear glasses? Yes / No Do you wear Contacts? Yes / No (If yes) what type of contacts _____
 4. Do you experience blur, headaches or eyestrain with computers use? Yes / No
 5. Are you interested in Laser (refractive) surgery to correct your vision? Yes / No
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Vision Insurance Information

Name of Vision Plan _____ Patient Relationship to insured _____
Insured ID number _____ Insured's Date of Birth _____
Insured's Name _____ Insured's Phone # _____

Medical Insurance Information

Name of Medical Insurance _____ Patient Relationship to insured _____
Insured ID number _____ Insured's Date of Birth _____
Insured's Name _____ Insured's Phone # _____



Photography Consent

Your annual eye exam at Stroudsburg Eye Specialists / Hazleton Eye Specialists includes an examination of the back of your eye. This examination is important in the early detection of disorders which may be harmful to your vision, including Glaucoma, high blood pressure, Diabetes, and Macular Degeneration. There are two available options for this exam.

***Option 1 (Recommended) – Digital Retinal Photography**

Digital Retinal Photography can be performed without dilation of your eyes and is more comfortable for you. The benefits to Digital Retinal Photography are:

- No light sensitivity
- No stinging
- No drops
- Maintain a digital record of the back of your eye

There is a nominal charge of \$40.00 for this service that will likely not be covered by insurance.

** Dilation may still be performed if deemed medically necessary*

Option 2 – Dilation

Dilation involves opening your Pupils with drops so that the doctor can look at the back of your eye. Dilation has the following drawbacks:

- Requires eye drops
- Blurry near vision
- Possible stinging
- Light Sensitivity

Please check one of the options below:

_____ I accept Retinal Photography at a cost of \$40.00

_____ I accept Dilation

Patient name (Print) _____

Patient signature _____ Date: _____