



# 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       |

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Name of Family Physician \_\_\_\_\_ Physician's Phone Number \_\_\_\_\_

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

<b>Medication/Vitamins/Supplements</b>	<b>Condition</b>
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*

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### **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

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**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: \_\_\_\_\_