

**PATIENT REGISTRATION FORM**

<b>First Name</b>	<b>MI</b>	<b>Last Name</b>	<b>Suffix</b>	<b>Sex: M / F</b>
<b>Home Address</b>			<b>Date of Birth</b>	
<b>City</b>	<b>State</b>		<b>Zip Code</b>	
Preferred Language	Race <input type="checkbox"/> Native American (Indian) <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian			
Ethnicity <input type="checkbox"/> Hispanic Origin. <input type="checkbox"/> Not of Hispanic Origin	<input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> White			
Home #	Work #		Cell #	
Social Security #	Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W		E-mail	
Patients' Employer Name, Address / Occupation				
Emergency Contact Name	Phone #		Relationship	
Referring Physician/	Phone #		City	
Primary Care Physician	Phone #		City	
Financially responsible person (if different from patient)				
Responsible person's address:			Phone #	
***Are you currently residing in a Skilled Nursing Facility or Rehabilitation Center?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is this visit related to an automobile accident or Workers' Compensation?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>INSURANCE INFORMATION</b>				
Primary Insurance:	Policy Holder Name:		DOB:	Sex: M / F
Secondary Insurance:	Policy Holder Name:		DOB:	Sex: M / F
Vision Insurance:				

**FINANCIAL POLICY STATEMENT**

Thank you for choosing our practice for your medical care. We are committed to providing you with the highest quality services available. Please read and sign the following policy. If we are contracted with your insurance company, we will accept assignment. All co-pays, co-insurance and deductibles are due and payable at time of service. Failure to provide necessary referrals or current accurate billing information will result in all charges for services the sole responsibility of the patient/responsible party. You will be responsible for any balances not covered by your insurance. A return check fee of \$36.00 will be assessed if your check is returned by your bank. Our cancellation and "no show" policy is as follows: First occurrence, patient will be charged a \$25.00 fee. Second occurrence, patient will be charged a \$35 fee. Third occurrence, patient will be charged a \$50 fee. The patient may be charged the full price of the scheduled office visit for any additional "no show" or any appointment cancellation that occurs within 24 hours of a scheduled appointment.

HIPAA - This office will comply with all aspects as printed in our Notice of Privacy Practice, and our privacy notice will be in compliance with all appropriate laws and regulations.

**PATIENT AUTHORIZATION**

I hereby authorize Eye Centers of America, LLC to apply for benefits on my behalf for services rendered. I request payments from Medicare, Medigap, and/or any other insurance company be made directly to Eye Centers of America, LLC. I certify that the information I have provided on this form is correct. I authorize the release of any necessary information for this or any related claim to the above named carrier or in case of Medicare Part B benefits.

I hereby attest that I have been given and reviewed the Notice of Privacy Practice.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**HIPAA NOTICE OF PRIVACY PRACTICE**

**Privacy Consent**

I understand that Eye Centers of America, LLC, "Notice of Privacy Practices" provides how my health information will be used and disclosed. The "Patient Rights" section describes my rights under the law. I have the right to review the notice before signing this consent. I understand that this notice may change and that I can request a revised copy. I understand that I have the right to request that we restrict how protected health information about me is disclosed for treatment, payment, or health care operations. I understand that Eye Centers of America, LLC, is not required to agree to this restriction, but you will honor this agreement.

I acknowledge by signing this form I consent to your use and disclosure to protect health information about my treatment, payment, and health care operations. I have the right to revoke this consent in writing with my signature. However, this revocation shall not affect any disclosures Eye Centers of America, LLC has already made in reliance prior to my consent. Eye Centers of America, LLC, provides this form to me to comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**Consent to Release Information**

I acknowledge that by signing this form, I permit Eye Centers of America, LLC, to release any information to the physician(s) involved in my care. I consent that Eye Centers of America, LLC, may call my house or designated locations and leave a message on voice mail or in person in reference to my appointment reminders and insurance items. In addition, Eye Centers of America LLC, may mail to my home appointment reminders and patient statements.

I designate the following representative(s) as being legally authorized to communicate with Eye Centers of America, LLC, on my behalf. If you do not designate anyone below, the Doctor/Eye Centers of America, LLC, will not be able to speak with anyone besides the patient regarding your medical condition.

I acknowledge and give my consent to Eye Centers of America, LLC, to use the standard of care images taken of my eyes. These images will be used for submission to a 3<sup>rd</sup> party imaging vendor for certification purposes only. All personal identifiers will be removed prior to images being used.

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**Signature**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Signature (Patient or Legal Guardian): \_\_\_\_\_ Date: \_\_\_\_\_

**NEW PATIENT MEDICAL HISTORY FORM**

Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**REASON FOR REFERRAL / VISIT (TELL US WHY YOU ARE HERE):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CHIEF COMPLAINTS (TELL US WHAT IS BOTHERING YOU):**

<input type="checkbox"/> Loss of Central Vision	<input type="checkbox"/> Glare from Bright Lights	<input type="checkbox"/> Swollen Eyelids
<input type="checkbox"/> Loss of Peripheral Vision	<input type="checkbox"/> Glare from Car Headlights	<input type="checkbox"/> Droopy Eyelids
<input type="checkbox"/> Loss of Night Vision	<input type="checkbox"/> Glare from the Sun	<input type="checkbox"/> Twitching of Eyelids
<input type="checkbox"/> Loss of Distance Vision	<input type="checkbox"/> Tearing from Bright Lights	<input type="checkbox"/> Floppy Eyelids
<input type="checkbox"/> Loss of Reading Vision	<input type="checkbox"/> Tearing from the Sun	<input type="checkbox"/> Poor Eyelid Closure
<input type="checkbox"/> Loss of Color Vision	<input type="checkbox"/> Headaches	<input type="checkbox"/> Bumps on Eyelid
<input type="checkbox"/> Flashes of Light	<input type="checkbox"/> Watery Discharge	<input type="checkbox"/> Growth on Eyelid
<input type="checkbox"/> Floaters	<input type="checkbox"/> Mucous Discharge	<input type="checkbox"/> Itchiness of Eyelids
<input type="checkbox"/> Shadow in Peripheral Vision	<input type="checkbox"/> Crusty Discharge	<input type="checkbox"/> Rash on Eyelids
<input type="checkbox"/> Distortion (of Straight Lines)	<input type="checkbox"/> Sand-Like Discharge	<input type="checkbox"/> Redness of Eyelids
<input type="checkbox"/> Objects Appear Smaller	<input type="checkbox"/> Aching Eye Pain	<input type="checkbox"/> Other:
<input type="checkbox"/> Sensitivity to Bright Lights	<input type="checkbox"/> Burning Eye Pain	<input type="checkbox"/>
<input type="checkbox"/> Sensitivity to Car Headlights	<input type="checkbox"/> Pinching Eye Pain	<input type="checkbox"/>
<input type="checkbox"/> Sensitivity to the Sun	<input type="checkbox"/> Stabbing Eye Pain	<input type="checkbox"/>
<input type="checkbox"/> Halos Around Car Headlights	<input type="checkbox"/> Foreign Body Sensation	<input type="checkbox"/>

Location: What is the site of the problem/which eye?  Right Eye  Left Eye  Both Eyes

Quality: What is the nature of the pain?  Constant  Intermittent  Improving  Worsening

Severity: Describe the severity of your pain/problem (on a scale of 1 to 10, with 10 being the worst) \_\_\_\_\_

Duration: When did the pain/problem start? \_\_\_\_\_

How long has the pain/problem been an issue? \_\_\_\_\_

Timing: Is the pain/problem worse in the morning, evening, or is it constant? \_\_\_\_\_

Context: Is the pain/problem associated with an activity? \_\_\_\_\_

Modifiers: What efforts has the patient made to improve the pain/problem (i.e. heat, artificial tears, other, etc.)?  
\_\_\_\_\_

History: Is this visit related to an automobile accident or Workers' Compensation? \_\_\_\_\_

<p><b><u>CONSTITUTIONAL SYMPTOMS</u></b></p> <p>Good General Health Lately    <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Recent Weight Change        <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Fever                                <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Fatigue                            <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Headaches                        <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Insomnia                          <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Hours of Sleep Each Night    _____</p>	<p><b><u>PSYCHIATRIC</u></b></p> <p>Memory Loss or Confusion    <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Nervousness                    <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Depression                       <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Insomnia                         <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Anxiety                           <input type="checkbox"/>Yes <input type="checkbox"/>No</p>	<p><b><u>HEMATOLOGIC/LYMPHATIC</u></b></p> <p>Slow to Heal After Cuts       <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Bleeding or Bruising Tendency                        <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Anemia                            <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Phlebitis                         <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Past Transfusion               <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Enlarged Glands               <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Blood Transfusion             <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Transfusion Reaction         <input type="checkbox"/>Yes <input type="checkbox"/>No</p>
<p><b><u>RESPIRATORY</u></b></p> <p>Chronic or Frequent Cough    <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Spitting up Blood               <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Shortness of Breath            <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Asthma or Wheezing           <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Shortness of Breath While Walking or Lying               <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Recent Upper Respiratory Infection                         <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Sleep Apnea                      <input type="checkbox"/>Yes <input type="checkbox"/>No</p>	<p><b><u>INTEGUMENTARY</u></b></p> <p>Rash or Itching                 <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Change in Skin Color          <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Change in Hair and Nails      <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Varicose Veins                 <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Breast Pain                       <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Breast Lump                     <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Breast Discharge               <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Skin Disorders                  <input type="checkbox"/>Yes <input type="checkbox"/>No</p>	<p><b><u>NUTRITION</u></b></p> <p>Supplements                    <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Tube Feed                        <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Eating Disorder                <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Vitamins/Minerals/Herbals   <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Liver Failure                    <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Difficulty Swallowing         <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Unintentional Weight Loss in 3 months               <input type="checkbox"/>Yes <input type="checkbox"/>No</p>
<p><b><u>MUSCULOSKELETAL</u></b></p> <p>Arthritis                         <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Joint Pain                        <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Joint Stiffness or Swelling   <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Muscle or Joint Weakness     <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Muscle Pain or Cramps        <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Muscular Disorder             <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Back Pain                        <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Cold Extremities               <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Difficulty in Walking          <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Spine Disease                  <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Fractures                        <input type="checkbox"/>Yes <input type="checkbox"/>No</p>	<p><b><u>EAR, NOSE, MOUTH AND THROAT</u></b></p> <p>Hearing Loss or Ringing       <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Hearing Aids                    <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Earaches or Drainage         <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Chronic Virus Problems       <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Rhinitis                          <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Nose Bleeds                     <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Mouth Sores                     <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Bleeding Gums                 <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Bad Breath or Bad Taste       <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Sore Throat/Voice Change    <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Swollen Glands in Neck       <input type="checkbox"/>Yes <input type="checkbox"/>No</p>	<p><b><u>NEUROLOGICAL</u></b></p> <p>Frequent Urination             <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Light Headed or Dizzy         <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Convulsions or Seizures       <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Numbness or Tingling         <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Tremors                          <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Weakness or Paralysis         <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Stroke                            <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Head Injury                      <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Speech Difficulties            <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Change in Gait                 <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Vision Difficulties             <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Glasses/Contact Lenses       <input type="checkbox"/>Yes <input type="checkbox"/>No</p>
<p><b><u>CARDIOVASCULAR</u></b></p> <p>Heart Trouble                   <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Chest Pain                       <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Angina Pectoris                <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Palpitations                     <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>No Heat or Cold Intolerance   <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Swelling of Feet or Ankles    <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Pacemaker                       <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Myocardial Infarction         <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Hypertension                   <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Heart Failure                    <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Valve Disease                  <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Heart Murmur                  <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Irregular Rhythm               <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>High Cholesterol               <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Peripheral Vascular Disease   <input type="checkbox"/>Yes <input type="checkbox"/>No</p>	<p><b><u>ENDOCRINE</u></b></p> <p>Glandular or Hormonal</p> <p>Problems                        <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Thyroid Disease                <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Excessive Thirst or Urination <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Skin Becoming Dryer          <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Change in Hat or Glove Size <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Diabetes                         <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>When were you diagnosed?    _____</p> <p>Type 1 or Type 2 (Please Circle)</p> <p>HGB A1C/HbA1c? _____ Date: _____</p> <p>Are You on Insulin             <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Times Per Day                  _____</p> <p>Are You on Dialysis           <input type="checkbox"/>Yes <input type="checkbox"/>No</p>	<p><b><u>GENITROURINARY</u></b></p> <p>Frequent Urination             <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Burning or Painful Urination                        <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Blood in Urine                 <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Change in Force or Stream                           <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Incontinence or Dribbling    <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Kidney Stones                  <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Sexually Transmitted Disease                         <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Sexual Difficulty               <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Male - Testicle Pain          <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Prostate Problems             <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Female - Pain with Periods                         <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Female - Irregular Periods   <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>HIV                                <input type="checkbox"/>Yes <input type="checkbox"/>No</p>

<b><u>GASTROINTESTINAL</u></b>		<b><u>PAST MEDICAL HISTORY</u></b>		<b><u>CURRENT MEDICATIONS</u></b>	
Loss of Appetite	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medical Condition	Year of Onset	Name	Dosage
Change in Bowel Movements	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____
Nausea or Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____
Frequent Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____
Painful Bowel Movements or Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____
Rectal Bleeding or Blood in Stool	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____
Abdominal Pain or Heartburn	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____
Peptic Ulcer (Stomach or Duodenal)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____
Hiatus Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____
Gastrointestinal Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____
Hemorrhoids	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____
Pancreatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____
Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____
Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____
Renal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____

<b><u>PAST SURGICAL HISTORY</u></b>		<b><u>PATIENT SOCIAL HISTORY</u></b>		
Surgeries	Date	<b><u>Marital Status</u></b>	<b><u>Use of Tobacco</u></b>	<b><u>Use of Illicit Drugs</u></b>
_____	_____	<input type="checkbox"/> Single	<input type="checkbox"/> Never	<input type="checkbox"/> Never
_____	_____	<input type="checkbox"/> Married	<input type="checkbox"/> Previous but Quit	<input type="checkbox"/> Type & Frequency
_____	_____	<input type="checkbox"/> Divorced	<input type="checkbox"/> Currently	_____
_____	_____	<input type="checkbox"/> Widowed	_____ Packs Daily	_____
Anesthesia Complications	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b><u>Use of Alcohol</u></b>	<b><u>Excessive Exposure at Home or Work to:</u></b>	
If yes, explain:	_____	<input type="checkbox"/> Never	<input type="checkbox"/> Fumes _____	
_____	_____	<input type="checkbox"/> Rarely	<input type="checkbox"/> Solvents _____	
_____	_____	<input type="checkbox"/> Moderate	<input type="checkbox"/> Chemicals _____	
_____	_____	<input type="checkbox"/> Daily	<input type="checkbox"/> Other _____	

<b><u>FAMILY MEDICAL HISTORY</u></b>			
	<u>Age</u>	<u>Diseases</u>	<u>If Deceased, Cause of Death</u>
Father	_____	_____	_____
Mother	_____	_____	_____
Brother(s)	_____	_____	_____
Sister(s)	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
Living Will/Advance Directive	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Would Like Information		

<b><u>LIST ALL ALLERGIES</u></b>			
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**PLEASE INFORM THE DOCTOR OF ALL PHYSICIANS  
YOU ARE CURRENTLY SEEING**

<u>SPECIALTY</u>	<u>PHYSICIAN NAME</u>	<u>ADDRESS</u>	<u>PHONE NUMBER</u>
<u>Ophthalmologist</u>	_____	_____	_____
<u>Optometrist</u>	_____	_____	_____
<u>Internist</u>	_____	_____	_____
<u>Endocrinologist</u>	_____	_____	_____
<u>Cardiologist</u>	_____	_____	_____
<u>Nephrologist</u>	_____	_____	_____
<u>Neurologist</u>	_____	_____	_____
<u>Podiatrist</u>	_____	_____	_____
<u>Vascular Specialist</u>	_____	_____	_____
<u>Other</u>	_____	_____	_____