

See Good • Look Good • Feel Good

Patient History Form |

724 Cambridge Marketplace Blvd Cambridge MD 21613



443-225-5377

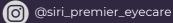
Date of Visit:		Email Address:
Last Name:	First Name	:: Last 4-digits SSN :
Home Phone:	Work Phone:	Mobile:
Employer:	Occupation:	DOB: Age:
INSURANCE		
Primary Insurance:		How did you hear about us? (Circle all that apply)
Primary Insurer's Name:		Family / Friend / Google / Social Media / Doctor
Symptoms (Circle all that	apply): Blurry vision / Flash	/ Other: nes / Floaters / Red eye / Pain / Double vision r day?
At the end of the day (Cir	cle all that apply): My eyes f	feel tired / I have headaches / My eyes feel dry tty / Red When? Always / Start of day / End of day
PERSONAL OCULAR HISTO	ORY: (Check all that apply)	PERSONAL MEDICAL HISTORY: (Check all that apply)
() Wears glasses		() Diabetes: Last A1C%
() Wears contact lenses		Last blood sugar mg/dL
() Lazy eye		Last Dr.'s appointment:
() Eye Surgery		() High Blood Pressure () High Cholesterol
		() Thyroid Disease
() Eye Trauma / Injury		() Autoimmune disease: Rosacea / Lupus / Lyme
() Cataract		disease / Rheumatoid Arthritis / Crohn's disease
() Macular degeneration		Other:
() Glaucoma		() Heart Disease () Stroke: Date
() Blindness		() Cancer: Type/s In Remission: Y () N ()
Other:		() HIV / AIDS: CD-4 Count Viral load:
FAMILY OCULAR HISTORY	: (Check all that apply)	FAMILY MEDICAL HISTORY: (Check all that apply)
() Lazy eye: Who?		() Diabetes: Who?
() Cataracts: Who?		() High blood pressure: Who?
() Macular degeneration:	Who?	
• •		() Stroke: Who?
() Blindness: Who?		() Cancer: Type/s
Other:		Who?

PLEASE PROCEED TO THE NEXT PAGE

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SOCIAL HISTORY: (Circle	all that apply)
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Non-smoker? YES / NO			
Current smoker? YES / NO	1/2 pack / day 1 pack/day	>1 pack a day	
Former smoker? YES			
Do you drink? YES / NO	How much?		
CURRENT MEDICATIONS:			
CURRENT DOCTORS:			
ALLERGIES / REACTION TO M	MEDICATION/S: YES / NO		
If YES, which medication/s and	d what type of reaction?		
ADE VOU DDECMANTS VEG	/ 110		
ARE YOU PREGNANT? YES /			
If YES, how many months?			

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

I authorize the professional office of my optometrist named above to release health information identifying me [including if applicable, my eyeglass/ contact lens prescriptions, information about my ocular health, HIV/AIDs, substance abuse treatment and my mental health] under the following terms and conditions:

* All professional fees / copays are due at the time of service. **NO REFUNDS. STORE CREDIT ONLY.** *

* No show fee of \$140 *

- 1. Detailed description of the information released:
- 2. To whom may the information be released [name (s) or class (es) of recipients]:
- 3. The purpose (s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as a purpose, if desired by the individual):
- 4. Expiration date of the event relating to the individual or purpose for the release:

It is completely your decision whether to sign this authorization form or not. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send the note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND I UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient/Legal Guardian Signature: Date of Signature: Relationship to Patient:

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