Patient Information

Date: _____
Patient: _____

Address: _____

_____
City State Zip

Race: Other, American Indian, Asian, Black or African American, Native Hawaiian or Pacific Islander White Decline

Preferred language: English, Punjabi, Russian, Spanish, Other

Ethnicity: Other Hispanic/Latino Declined

Sex: __ M __ F **Birthdate:** _____

Marital Status: ___ Single ___ Married ___ Seperated ___ Divorced ___ Widowed

Occupation: _____
Employer: _____
Employer Phone: _____

Spouse's Name: _____
Spouse's Birthdate: _____
Occupation: _____
Employer: _____

Whom may we thank for referring you?

_____

Contact Numbers:
Home: _____
Work: _____
Cell: _____

Best time and place to reach you:

_____

Email address: _____

_____

Would you like to receive our newsletter by email? Y N

In Case of Emergency, Contact: (specify someone who does not live in your household)
Name: _____
Relationship: _____
Home # / Work #:

_____

The following people have permission to access my records:

_____
_____
_____
_____

Insurance and Privacy Information

Who is responsible for this account: (circle one)
Self Spouse _____ Parent _____

Assignment and Release:

I, the undersigned, certify that I (or my dependant) have insurance coverage through _____, and assign directly to Dr. Swiecicki all insurance benefits, if any, otherwise payable to me for services rendered.

I understand that I am financially responsible for all charges whether or not paid by insurance.

I hereby authorize the doctor to release all information necessary to secure the payment of benefits.
I authorize the use of this signature on all insurance submissions.

I acknowledge that I received a copy of the Notice of Privacy Practices and the Financial Policy.

Updates: Initials: Date:

_____ _____ _____ _____ _____
Responsible Party Signature Relationship Date _____ _____

Social History

Do you drive?	Yes	No	Are you interested in Lasik?	Yes	No
Do you have trouble with night vision?	Yes	No	Do you need safety glasses?	Yes	No
Do you use a computer?	Yes	No	Are you interested in contact lenses?	Yes	No
Do you have a pilot's license?	Yes	No	Do you smoke?	Yes	No
Do you use firearms?	Yes	No	Do you use tobacco?	Yes	No
Are you pregnant or nursing?	Yes	No	Do you drink alcohol?	Yes	No
Do you have children between 6 -12 months of age?	Yes	No	Do you use sports goggles?	Yes	No
			Do you use swim goggles?	Yes	No

Eye History

What brings you in today?

Date of last eye exam:

Name of last eye doctor:

Do you currently have glasses? Yes No

If yes, when do you use them? (circle)

All the time Driving only
Reading only Occasionally
Back up to contacts Never

Do you wear contact lenses? Yes No

Do you have any special concerns you would like to discuss with the doctor? Yes No

Please indicate if you have any of the following:

__ Blurred vision - Distance
__ Blurred vision - Near
__ Eyestrain
__ Double vision
__ Loss of vision
__ Halos/Glare
__ Dizzy spells
__ Fainting spells/blackouts
__ Headaches
__ Migraines
__ Twitching eyelids
__ Burning
__ Itchy eyes
__ Water eyes
__Dry Eyes
__Discharge
__ Red eyes
__ Light Sensitive
__ Flashes
__ Floaters
__ Cross eye
__ Eye injury:
__ Eye surgery:

Medical History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer. ___ Yes, I would prefer to discuss my medical history directly with my doctor

Family Physician: Last Physical Exam:

Please list any medications you are currently taking (including eye drops, vitamins, and home remedies):

Are you allergic to any medications: Yes No If yes, please list:

Do you currently, or have you ever had, any problems in the following areas:

(check *none* if you do not have any of the following conditions)

Allergic/Immunology:
__ drug allergy
__ environmental allergy
__ rheumatoid arthritis
__ lupus
__other
__ none

Ear, Nose, Mouth and Throat
__ upper respiratory tract infection
__sinus problems
__other
__ none

Stomach/Digestive
__ Crohn's
__ colitis
__ ulcer
__ digestive
__ other
__ none

Skin Problems
__ eczema
__ rosacea
__ psoriasis
__ other
__ none

Psychiatric
__ depression
__ panic disorder
__ schizophrenia
__ anxiety
__ other
__ none

Cardiovascular
__ heart disease
__ high blood pressure
__ stroke
__ vascular disease
__ high cholesterol
__ other
__ none

Endocrine
__ Diabetes
Insulin? Yes No
__ thyroid dysfunction
__ hormonal dysfunction
__ Sjogren's Syndrome
__ other
__ none

Genitourinary
__ herpes
__ chlamydia
__ gonorrhea
__ HIV
__ syphilis
__ hepatitis (type __)
__ none

Musculoskeletal
__ fibromyalgia
__ muscular dystrophy
__ osteoarthritis
__ other
__ none

Respiratory
__ asthma
__ bronchitis
__emphysema
__sleep apnea
__ CPAP
__ other
__ none

Constitutional
__ developmental disability
__ weight loss/weight gain
__ fever
__ fatigue
__ trauma
__ cancer
__ other
__ none

Eyes
__ glaucoma
__ cataracts
__ macular degeneration
__ surgery
__ iritis
__ pterygium
__ other
__ none

Blood Problems
__ anemia
__ large volume blood loss
__ leukemia
__ other
__ none

Neurological
__ multiple sclerosis
__ epilepsy
__ other
__ none

Diabetes History
Last blood glucose:
Last A1c:
Last blood pressure:

Podiatrist:
Dentist:
Endocrinologist: