LEVIN eyecare

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you.

PATIENT INFORMATION

Today's Date: _____ Date of Birth: _____ Social Security #: _____-_____-_____

Patient Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Preferred Phone Number: _____ Alternate Phone Number: _____

Email address:_____ **(sign up for our patient portal which will enable you to request medication refills, schedule appointments and communicate with your doctor)**

Who is your Primary Care Physician? _____

What pharmacy do you use? _____ Location? _____

In case of an emergency, who should we contact? _____ Relationship: _____

Preferred Phone Number: _____ Alternate Phone Number: _____

SEX: ☐ Male ☐ Female

☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ PARTNERED ☐ MINOR ☐ OTHER

WHICH CATEGORY BEST DESCRIBES YOUR RACE? *(Please check any you fee apply)*

☐ White ☐ Native American/Alaska Native ☐ Native Hawaiian/Other Pacific

☐ Black/African American ☐ Asian ☐ Other ☐ Decline

DO YOU CONSIDER YOURSELF HISPANIC/LATINO? ☐ YES ☐ NO ☐ DECLINE

WHAT IS YOUR PRIMARY LANGUAGE SPOKEN? ☐ English ☐ Spanish ☐ Other

INSURANCE

Who is the primary account holder of the policy? _____

Relationship to you: _____ Their Date of Birth: _____

ASSIGNMENT AND RELEASE: I certify that I, and/or my dependent(s), have insurance coverage and assign directly to doctor 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 authorize the use of my signature on all insurance submissions. To the extent permitted by law, the doctor may use my health care information and may disclose such information to my insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ Date: _____

Patient's Signature

OCULAR / MEDICAL / SOCIAL HISTORY QUESTIONNAIRE

PLEASE MARK/IDENTIFY THE CONDITIONS THAT APPLY TO YOU OR YOUR FAMILY MEMBER, BELOW
(please specify which family member, i.e. mother, sister, grandfather, etc)

Eye Diseases/Problems:

	SELF	FAMILY MEMBER		SELF	FAMILY MEMBER
• Cataracts:	_____	_____	• Retinal Disease:	_____	_____
• Glaucoma:	_____	_____	• Floaters/Flashes:	_____	_____
• Macular Deg:	_____	_____	• Corneal Dystrophy:	_____	_____
• Dry Eye:	_____	_____	• Eye Injury:	_____	_____
• Eye Surgery:	_____	_____	• Lazy Eye/Amblyopia:	_____	_____

Systemic Diseases/Problems:

• Arthritis:	_____	_____	• Diabetes:	_____	_____
• Asthma:	_____	_____	• High Blood Pressure:	_____	_____
• Allergies:	_____	_____	• High Cholesterol:	_____	_____
• Thyroid:	_____	_____	• AIDS/HIV/STD:	_____	_____
• Heart Disease:	_____	_____	• Other:	_____	_____

Review of Systems: (*please check all that apply to you*)

☐ GENERAL: weight loss, fever, headache
☐ EAR/NOSE/THROAT: hearing loss, sinus
☐ HEART: chest pain, irregular heart beat
☐ RESPIRATORY: shortness of breath, wheezing, asthma
☐ DIGESTIVE: heartburn, diarrhea
☐ MUSCLES: arthritis, muscle aches
☐ OTHER: _____
☐ NEUROLOGIC: paralysis, numbness
☐ SKIN: rashes, eczema
☐ PSYCHIATRIC: depression, anxiety, mental illness
☐ ENDOCRINE: diabetes, thyroid
☐ CANCER: any type
☐ BLOOD: anemia, sickle cell, bleeding problems

Do you wear glasses? ☐Single Vision ☐Progressive ☐Readers
Do you wear contact lenses? ☐Dailies ☐Monthly ☐RGP
Do you wear bifocals? ☐Yes ☐No **Date of last eye exam?**_____

MEDICATIONS

If you have a list, please give to front desk, please include all vitamins, herbals and eye drops:

_____
_____
_____

☐ **I do not currently take any medications**

ALLERGIES

Please list:

_____
_____
_____

☐ **I do not have any known drug allergies**

SOCIAL HISTORY

SMOKING STATUS:
☐ Current every day smoker ☐ Former smoker (year quit:_____) ☐ Never smoked ☐ Unknown

Do you drink alcohol? _____ Do you use recreational drugs? _____

Female patients: Are you pregnant? _____ Number of children: _____

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