**\*How did you hear**

**about us?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Welcome To Our Office**

EYE CARE BY DR. BARRY HUSE

\*Patient’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender Assigned st Birth Male/ Female Preferred Pronouns: \_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Text ok? Y/N

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email ok? Y/N

Emergency Contact, Number, and Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician Name and Office Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vision Insurance Information**

Name of Insured Person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_

Birth Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_

Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Insurance Information**

Name of Insured Person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_

Birth Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_

Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I understand that I am responsible for any balance not paid by my insurance. I understand that my primary insurance will be billed and it is my responsibility to bill any secondary coverage. Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\***

**I understand that I will be charged a $45 cancellation fee if I cancel my appointment in less than 24 hours, or I fail to show up to my appointment. I understand that cancellation fees will need to be paid in full before I am able to be rescheduled. Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\***

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Health History Form**

**Reason for Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please indicate if you have medical conditions involving the following body systems:**

1. General Constitution: Y/N
2. Ears/Nose/Throat/Mouth: Y/N
3. Heart Conditions: Y/N
4. High Blood Pressure: Y/N
5. Asthma or Lung Conditions: Y/N
6. Genitourinary: Y/N
7. Muscle/Joint Conditions: Y/N
8. Stomach/Intestinal Conditions: Y/N
9. Skin Conditions: Y/N

1. Stroke/Neurological Disease: Y/N
2. Mental Health Conditions: Y/N
3. Endocrine (e.g. Thyroid): Y/N
4. Diabetes: Y/N Date Diagnosed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Blood Disorders: Y/N
6. Allergies/Immunologic: Y/N
7. Cancer Y/N
8. Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please specify conditions that were marked Y** (Arthritis, GERD, Anxiety etc.):

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

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

**Do you have any of the following eye diseases or eye symptoms?**

Glaucoma: Y/N

Dry Eyes: Y/N Cataracts: Y/N

Double Vision: Y/N

Macular Degeneration: Y/N Retinal Detachment: Y/N Eye Surgery: Y/N

Other Disease:

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

Itch: Y/N

Lazy Eye: Y/N

Burn: Y/N

Water: Y/N

**Are you a current/previous/non-smoker? (circle) Do you use alcohol? Daily Socially None (circle)**

**Other substances? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you wear glasses/contact lenses/no correction? (circle)**

**Medications:** Please list all medications you currently take, including any over the counter meds:

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

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

**Medication Allergies:** Please list all medications that you have allergies to:

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

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**IMMEDIATE FAMILY HISTORY**

Glaucoma: Y/N Relation\_\_\_\_\_\_\_\_ Diabetes: Y/N Relation\_\_\_\_\_\_\_\_\_

Retinal Detachment: Y/N Relation\_\_\_\_\_\_\_\_ High Cholesterol: Y/N Relation\_\_\_\_\_\_\_\_\_

Cataracts: Y/N Relation\_\_\_\_\_\_\_\_ Heart Issues: Y/N Relation\_\_\_\_\_\_\_\_\_

Crossed/Lazy Eye: Y/N Relation\_\_\_\_\_\_\_\_ High Blood Pressure: Y/N Relation\_\_\_\_\_\_\_\_\_

Macular Degeneration: Y/N Relation\_\_\_\_\_\_\_\_ Thyroid Issues: Y/N Relation\_\_\_\_\_\_\_\_\_

Blindness: Y/N Relation\_\_\_\_\_\_\_\_ Cancer: Y/N Relation\_\_\_\_\_\_\_\_\_