



Douglas B. Albright, O.D., F.A.A.O.      Jeannette A. Powell, O.D.

**PERSONAL INFORMATION FORM**

Please fill in all blanks on both sides to the best of your ability and sign where designated.

Name \_\_\_\_\_ Date \_\_\_\_\_

SSN \_\_\_\_/\_\_\_\_/\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex M F Marital Status: Single Married Divorced Widowed Separated

How did you find us? Insurance Phone Book Internet Friend \_\_\_\_\_ Other \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_

If a student, name of school \_\_\_\_\_ Retired: Y N

Primary care physician \_\_\_\_\_ Spouse or Parent's Name \_\_\_\_\_

**In case of emergency, contact \_\_\_\_\_ Relation \_\_\_\_\_**

**Primary Phone # \_\_\_\_\_ Secondary # \_\_\_\_\_**

**RESPONSIBLE PARTY**

Name \_\_\_\_\_ Relation \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_

SSN \_\_\_\_/\_\_\_\_/\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone \_\_\_\_\_

**INSURANCE INFORMATION**

Please have insurance card ready to make a copy

Medical Insurance Y N Company \_\_\_\_\_ Policy # \_\_\_\_\_

Vision Insurance Y N Company \_\_\_\_\_ Policy # \_\_\_\_\_

Medicare Y N If so, co-insurance Y N Company \_\_\_\_\_

I authorize the release of any medical information necessary to process all claims and the release of payment for medical benefits to my physician. I acknowledge I will be responsible for any services my insurance does not cover including refractions.

**Patient's Signature** or representative \_\_\_\_\_ Date \_\_\_\_\_

**HEALTH HISTORY**

Reason for today's exam? \_\_\_\_\_

How long ago did the problem start? \_\_\_\_\_

Date of last exam \_\_\_\_\_ Name of previous Eye doctor \_\_\_\_\_

Do you currently wear glasses? Y N if so, for what? Distance Reading Driving Computer

Do you work on a computer? Y N if so, how many hours per day? \_\_\_\_\_

PAT # \_\_\_\_\_ APPT: \_\_\_\_\_ INS: \_\_\_\_\_ Rm: \_\_\_\_\_



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HEALTH HISTORY CONTINUED

Do you wear contact lenses? Y N if so, what kind? \_\_\_\_\_

Are you interested in contact lenses? Y N Are you interested in laser vision correction? Y N

Smoker? Y N how many packs per day? \_\_\_\_\_ Alcohol? Y N how many drinks per week? \_\_\_\_\_

What hobbies or sports do you participate in? \_\_\_\_\_

Current Medications being taken:

Allergies to anything:

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

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

Circle if you or your family have a history of the following: S = self F = family (identify family relationship)

Allergies	S	F	_____	Flashes of light	S	F	_____	Pupil Dysfunction	S	F	_____
Amblyopia	S	F	_____	Floaters	S	F	_____	Pregnant	S	F	_____
Arthritis	S	F	_____	Frequent Headaches	S	F	_____	Retinal Detachment	S	F	_____
Burning Eyes	S	F	_____	Glaucoma	S	F	_____	Retinitis Pigmentosa	S	F	_____
Blindness	S	F	_____	High Blood Pressure	S	F	_____	Retinopathy	S	F	_____
Cancer	S	F	_____	Keratoconus	S	F	_____	Strabismus	S	F	_____
Cataract	S	F	_____	Lazy Eye	S	F	_____	Stroke	S	F	_____
Color Deficiency	S	F	_____	Lupus	S	F	_____	Sjogren's	S	F	_____
Diabetes	S	F	_____	Macular Degeneration	S	F	_____	Thyroid	S	F	_____
Dry Eye Syndrome	S	F	_____	Migraines	S	F	_____	Vascular Disease	S	F	_____
Excessive Tearing	S	F	_____	Ocular Infection	S	F	_____	Double Vision	S	F	_____
Eye Surgery	S	F	_____								

Past Medical History:

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

Past Surgical History:

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

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me, or my child during the period of such eye care to third party payers. I authorize and request my insurance company to pay directly to the eye doctor insurance benefits otherwise payable to me. I agree to be responsible for payment of all services rendered on behalf of my dependants.

Sign: \_\_\_\_\_

Date: \_\_\_\_\_