

# James Eugenides, O.D., P.A.

(Please Print)

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

Patient's Legal Name: \_\_\_\_\_

Last First Middle Initial

Title:  Mr.  Mrs.  Miss  Ms.  Dr.  Rev. Sex:  Male  Female Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ Social Security \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Email Address: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Primary Ins. Co.: Medicare or other: \_\_\_\_\_ Medicare Policy # \_\_\_\_\_

Supplemental / Secondary Ins.: \_\_\_\_\_ Autocrossover?  YES  NO

Vision Insurance Plan: \_\_\_\_\_

If married, name of spouse: \_\_\_\_\_

If minor, parents name: \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

Occupation/Hobbies: \_\_\_\_\_

## Medical / Family / Social History / Review of Systems

List of current medications: \_\_\_\_\_

List past major surgeries: \_\_\_\_\_

List past eye surgeries: \_\_\_\_\_

List any medications to which you are allergic: \_\_\_\_\_

Please list relatives with.  Glaucoma \_\_\_\_\_  Retinal Detachment \_\_\_\_\_  
 Diabetes \_\_\_\_\_  Blindness \_\_\_\_\_  Macular Degeneration \_\_\_\_\_

Do you use tobacco products?  YES  NO \_\_\_\_\_ # packs per day.

Are you interested in contact lenses?  YES  NO \_\_\_\_\_ Are you wearing contacts?  YES  NO

If so, please list brand and type: \_\_\_\_\_ Daily or extended wear?  Daily  Extended Wear

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

<u>Vascular/Cardiovascular</u>	YES	NO
Irregular Beat		
Heart Attack		
Heart Disease		
Blood Pressure		
Stroke		
High Cholesterol		
<u>Respiratory</u>		
Lung Disease		
Asthma		
COPD		
<u>Lymphatic / Hematologic</u>		
Bleeding Problems		

<u>Genitourinary</u>	YES	NO
Kidney Problems		
Kidney Stones		
Prostate Problems		
<u>Gastrointestinal</u>		
Ulcers		
<u>Bones / Joints / Muscles</u>		
Arthritis		
<u>Endocrine</u>		
Thyroid Disease		
Diabetes		
<u>Psychiatric</u>		
<u>Integumentary (skin)</u>		
<u>Allergies / Immunology</u>		
List:		

<u>Neurological</u>	YES	NO
Headache		
Parkinsonism		
<u>Ear / Nose / Throat</u>		
Sinus Problems		
<u>Eyes</u>		
Blurred Vision		
Double Vision		
Flashes / Floaters		
Cataracts		
Glaucoma		
Tearing/Mattering		
Eye Strain		
Eye Irritation		
Last Eye Exam: ____/____/____		

Other: \_\_\_\_\_

Medical Doctor: \_\_\_\_\_ Last Visit: \_\_\_\_/\_\_\_\_/\_\_\_\_

I authorize James Eugenides, O.D., P.A. to release any medial information required to process my claims. I hereby authorize my insurance benefits be paid directly to James Eugenides, O.D., P.A. and understand that I am responsible for any non-covered services.

Lifetime patient signature (or parent / guardian if minor): \_\_\_\_\_

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