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:

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

Other: _____

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

Neurological	**YES**	**NO**
Headache		
Parkinsonism		
Ear / Nose / Throat		
Sinus Problems		
Eyes		
Blurred Vision		
Double Vision		
Flashes / Floaters		
Cataracts		
Glaucoma		
Tearing/Mattering		
Eyestrain		
Eye Irritation		
Last Eye Exam:	/	/

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: _____/_____/_____

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