



Patient Name: «Full_Name»

Welcome to TSO TELFAIR

First Name: _____ MI: _____ Last Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

SSN: _____ Date of Birth: _____ Home Phone: _____ Cell Phone: _____

Preferred Number to call: _____ Email Address: _____

Guardian: _____ Emergency Contact: _____ Emergency Phone: _____

How were you referred to our office? (check all that applies)

Google/Yahoo/Advertisement Insurance Listing Drive by School Doctor

Friend/Family: _____ Patient: _____ Other: _____

Primary Insurance Information

Prim. Insurance Name: _____ Insured Full Name: _____

Insured DOB:«Ins_1_Birthday» Insured ID # «Ins_1_ID» _____ Group #«Ins_1_Policy_Group» _____

Patient Relationship to Insured _____ Patient Status _____

Self Spouse Child Other Single Married Other Full-time student

Part time student Employed

Secondary Insurance Information

Secondary Insurance: _____ Insured Full Name: _____

Insured DOB: _____ Insured ID # _____ Group # _____

Patient Relationship to Insured: «Ins_2_Relationship» _____

Self Spouse Child Other | _____

Please Read: In order to control the cost of billing, we ask that the patient’s portion is paid at the time services are rendered unless other arrangements are mad in advanced. We would rather control costs than be forced to raise our fees. All professional services and materials are charged to the patient. The undersigned with ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collect fees. There will be a service charge on all returned checks. Payment from my insurance is to be paid directly to TSO Telfair. I understand that insurance will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed. I acknowledge that I have received your Notice of Privacy Practices. **All Professional fees are non-Refundable.**

Signature: _____ Date: _____



Patient Name: «Full_Name»

Patient History and Information

Primary Care Physician: _____ **Referring Physician:** _____

What is the main reason for today's exam: _____

Last eye exam date: _____ Last health exam date: _____

Past Illness or Injuries: _____ Past Surgeries: _____

Current Medications: _____ Current Eye Drops: _____

Medicines Allergic: _____ Specific Allergies: _____

REVIEW OF OCULAR SYSTEM

	Yes	No		Yes	No		Yes	No
Blurred Vision Distance			Flashes of Light			Itchy Eyes		
Blurred Vision Near			Floaters			LASIK		
Cataract			Foreign Body Sensation			Macular Degeneration		
Cataract Surgery			Glaucoma			PRK		
Crossed Eye			Halos			Retinal Detachment		
Diabetic			Headaches			Tearing		
Dry Eye			Infection			Trauma		

Medical History Questionnaire

Family Ocular History

	Yes	No
Glaucoma		
Blindness		
Cataract(s)		
Macular Degeneration		
Retinal Detachment		
Crossed/Lazy Eye		

Relationship :

Family Medical History

	Yes	No
Arthritis		
Diabetes		
Hypertension		
High Cholesterol		
Thyroid		
Cardiovascular		
Cancer		
Others		

Relationship:

REVIEW OF SYSTEM

	Yes	No		Yes	No		Yes	No
Fatigue			Crohns Disease			Anxiety		
Fever			IBS			Depression		
Chronic Cough			Eczema			T1 Diabetes		
Dry Mouth			Itching			T2 Diabetes		
Runny Nose			Rosacea			Hyperthyroid		
Congestion			Headache			Hypothyroid		
Heart Disease			Migraines			Anemia		
High Cholesterol			MS			Bleed Disorder		
Hypertension			Numbness			Allergy		
Vascular Disease			Seizures			Pregnant?		
Asthma			ADHD			Nursing?		



Patient Name: «Full_Name»

Social History

Current Occupation: _____ Years: _____ Employer: _____

Do you engage in regular exercise? Yes No

Do you drink alcohol Yes No

If yes, how often? Occasional 1/day 2-3/day 4+/day

Do you smoke? Yes No

If yes, how often? Occasional ½ pk/day 1pk/day 1+/day

Do you use illegal drugs? Yes No

Hobbies/Interests: _____