PATIENT INFORMATION

Eugene K.L. Young, O.D.
1125 Bethel Street
Honolulu, Hawaii 96813

Patient Name:Mr. Mrs. Ms. Dr. _____
(Last) (First) (Middle)

Address:_____

City:_____ State:_____ Zip: _____

Home Phone: _____ Work Phone: _____

Birthdate: _____Social Security #:_____

Name of Employer: _____ Occupation:_____

If full time student, name of school: _____

Name of person responsible for account:_____
Address/Phone (if different from above_____

Name of Spouse:_____
Spouse's Employer:_____

Emergency contact person:_____
Relationship:_____Phone:_____

Nearest relative not living with you:_____
Relationship:_____Phone:_____

Whom may we thank for referring you? _____ Yellow Pages
_____ Talking Phone Book
_____ Downtown Planet
_____ Friend/Relative (name)_____
_____ Other _____

For office use only

INSURANCE INFORMATION

First Insurance Company _____Effective Date:_____
Subscriber name
_____Employer:_____
Social Security # _____ Birthdate
_____
Group # /Policy #
_____
Relationship to patient: _____ self _____ spouse _____ child _____ other

Second Insurance Company _____Effective Date:_____
Subscriber name
_____Employer:_____
Social Security # _____ Birthdate
_____
Group # /Policy #
_____
Relationship to patient: _____ self _____ spouse _____ child _____ other

♀ MEDICAL HISTORY QUESTIONNAIRE ♂

Name _____ Date _____

Date of *last eye examination* _____ *By whom* _____

Name of your family doctor _____ Last seen: _____

Medications you currently take (prescription, over-the-counter, supplements) _____

_____

Are you allergic or sensitive to any medicines? Yes ____ No ____ If yes, *please list* _____

_____

Surgeries you had (cataract, tonsils, heart, etc) _____

General health problems -- past or present	***Yes***	***No***	***Please explain …***
Eyes *(Blur, pain, vision loss, discharge, etc.)*			
Constitutional *(headaches, fever, fatigue, weight loss/gain, etc.)*			
Ears, Nose, Throat *(sinus, hearing loss, chronic cough, etc.)*			
Cardiovascular *(High blood pressure, stroke, heart, etc.)*			
Respiratory *(Asthma, emphysema, etc.)*			
Kidney, Bladder, Genital			
Muscles, Bones, Joints *(Arthritis, osteoporosis, etc.)*			
Skin *(herpes, acne, skin cancer, etc.)*			
Endocrine *(Diabetes, thyroid, etc.)*			
Allergic / Immunologic *(Hayfever, lupus, etc.)*			
Blood / Lymph *(High cholesterol, HIV or AIDS, etc.)*			
Neurological *(Multiple sclerosis, Parkinson's, etc.)*			
Psychiatric *(Anxiety, depression, etc.)*			
Family History		***Relationship to Patient or Comments***	
Eye diseases, *including glaucoma*			
Diabetes			
Heart disease, *High Blood Pressure*			
Cancer			
Stroke			
Other			
Social History			***Please describe …***
Hobbies ✈ υ I θ Ω ---- ***please list*** ➔			
Do you wear ***contact lenses***? ***please circle*** ➔			Soft Hard Disposable Soft
Are you interested in ***laser refractive surgery***?			
Do you drink alcohol?			*How much?*
Do you smoke?			*How much?*

AUTHORIZATION

To my knowledge all of the above information is true and accurate. I understand that I am responsible for all charges for services provided by Eugene Young, O.D., Inc. and that professional fees are due at the time services are rendered. I understand I will be charged an *additional $10.00 for any checks that are returned* for insufficient funds. I authorize *release of any medical information* necessary to process my insurance claims and request payment of insurance benefits to either myself or the party who accepts assignment/participation with my insurance company.

_____ _____

Signature of Patient/Guardian **Date**

(eyhealth040303)