VITTONE EYE SURGICAL ASSOCIATES

Name: First_____ Middle_____ Last _____ Date_____

Address _____ City_____ State_____ Zip _____

Phone: Home (_____) _____ Work (_____) _____ Cell (_____) _____

Date of Birth:_____ Age:_____ Sex: ☐ Male ☐ Female Social Security Number:_____

Primary Care Physician:_____ Phone (_____) _____

Place of Employment:_____ ☐ Full-Time ☐ Part-Time

Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single

Who should we contact in case of an emergency:

Name_____ Relationship_____ Phone (_____) _____

☐ I acknowledge that I have received the Notice of Privacy Practices.

Signature _____ Date_____

Relationship to Patient_____

You may discuss my health information with the following people:

Name_____ Relationship_____

Name_____ Relationship_____

INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Company Name _____

Subscriber's Name_____

Subscriber: Date of Birth_____ Social Security Number_____

Relationship to the Insured Person: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

SECONDARY INSURANCE

Insurance Company Name _____

Subscriber's Name_____

Subscriber: Date of Birth_____ Social Security Number_____

Relationship to the Insured Person: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

"I request that payment of authorized insurance benefits be made either to me or on my behalf to Ronald B. Vittone for any services furnished by that physician or his employees. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I also understand that some insurance companies pay fixed allowances or only a percentage of the charges. It is my responsibility to pay any deductible, co-payment and/or any balance not paid by my insurance company."

Signature_____ **Date**_____

MY MEDICATIONS

Date:_____

Patient Name:_____ Date of Birth:_____

Medication:	Dose Strength:	Frequency:	Form: Pill, Liquid, Drops

Please list allergies and prior surgeries on other side.

Allergies: **Reactions:**

_____

_____

_____

_____

_____

_____

_____

Prior Surgeries: **Weight/Height:**

_____

_____

_____

_____

_____

_____

_____

NAME_____ DATE _____

CHIEF COMPLAINT
(reason for being here today)

_____

_____

_____

_____

DO YOU HAVE (please circle)

Blurred vision	Double vision
Sensitivity to light	Eye itching, burning, tearing
Problems with glare	Eye dryness
Floaters in your vision	Eye discomfort
Flashing lights	Puffy eyes
Poor side vision	Mattering of eyes/lids
Poor night vision	Spasm of eye lids
Pressure in or behind eye	Eye which bulges out

Other _____

_____

PERSONAL AND FAMILY MEDICAL HISTORY

	You	Family (relationship)
Cataracts		
Glaucoma		
Macular degeneration		
Blindness		
Lazy eye/crossed eye		
Eye surgery		
Eye disease/tumor		
Other		
Diabetes		
High blood pressure		
Heart disease		
Arthritis		
Thyroid disease		
Lung disease		
Neurological disease		
Cancer		
Cholesterol		
Other		
Weight		

Email: _____

SOCIAL HISTORY:

Race: White__ Black__
Asian__ Other__

Primary Language: _____

Smoking: Never__ Former__
Daily__ Occasional__
Chewing Tobacco__

Alcohol: Never__ Social__
Daily__ Occasional__

Have you ever received a pneumonia vaccination?
Yes__ No__

Family Doctor_____