TABOR EYE
CLINIC

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your health.

Patient Information

Date _____

Name _____ Soc. Sec # _____

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____ Sex □ M □ F Age _____ Birthdate_____

□ Single □ Married □ Widowed □ Divorced Race: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Other

Employer (or school) _____ Occupation (or grade) _____

Notify in case of emergency _____ Phone _____

How did you hear about us? ☐ Newspaper (name of paper) _____ ☐ Radio ☐ Facebook

☐ Website / Internet search ☐ Referral (name) _____ ☐ Other _____

Primary Insurance

Name of Primary Insurance Holder _____

Relation to Patient _____ Birthdate _____ Soc. Sec # _____

Address (if different from patient) _____

City _____ State _____ Zip _____ Home Phone _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____ Phone _____

Contract # _____ Group # _____ Subscriber # _____

Name(s) of other dependents under this plan _____

Additional Insurance

Is patient covered by additional insurance? ☐ Y ☐ N

Name of Insurance Holder _____

Relation to Patient _____ Birthdate _____ Soc. Sec # _____

Address (if different from patient) _____

City _____ State _____ Zip _____ Home Phone _____

Insurance Company _____ Phone _____

Contract # _____ Group # _____ Subscriber # _____

Name(s) of other dependents under this plan _____

Patient Visual and Health Information

REVIEW OF SYSTEMS Do you have a significant history or have you been treated for:

Diabetes	Y N	Heart Problems	Y N	Arthritis	Y N
Sinus congestion	*Y N*	*High Blood Pressure*	*Y N*	*Muscle / joint pain*	*Y N*
Chronic cough	Y N	Vascular disease	Y N	Anemia, other	Y N
Dry throat, mouth	*Y N*	*Asthma*	*Y N*	*Bleeding problems*	*Y N*
Skin cancer	Y N	Emphysema	Y N	Kidney disease	Y N
Other skin problems	*Y N*	*Ulcers*	*Y N*	*Bladder problems*	*Y N*
Allergies / Hay fever	Y N	Intestinal disease	Y N	Anxiety	Y N
Lupus, Sjogrens, other	*Y N*	*Headaches*	*Y N*	*Depression*	*Y N*
Fever, weight loss	Y N	Migraines	Y N	Insomnia	Y N
Thyroid problems	*Y N*	*Seizures*	*Y N*	*Cancer*	*Y N*
Other major illness	Y N				

List any other health issues _____

_____

_____

List any significant surgery _____

LIST ANY MEDICATIONS (including oral contraceptives and over the counter medications):

_____

_____

_____

Are you allergic to any medications? _____

FAMILY HISTORY

Does anyone in your family have any general health problems?

Glaucoma	Y N	High blood pressure	Y N	Arthritis	Y N
Cataracts	*Y N*	*Cancer*	*Y N*	*Stroke*	*Y N*
Macular Degeneration	Y N	Diabetes	Y N	Kidney disease	Y N
Blindness	*Y N*	*Heart disease*	*Y N*	*Thyroid disease*	*Y N*

SOCIAL HISTORY

Do you smoke?	Y N	Have you ever had HIV/Hepatitis?	Y N	Do you use a computer?	Y N
Do you drink alcohol?	*Y N*	*Do you drive?*	*Y N*	*Are you bothered by glare?*	*Y N*
Are you pregnant/nursing?	Y N	Do you have vision trouble while driving?	Y N		

PLEASE CIRCLE ANY OF THE FOLLOWING WHICH APPLY TO YOUR EYES:

Burning	Mucous discharge	Headaches	Eye injury / disease
Itching	Tearing /watering	Floating spots	Vision therapy
Gritty feeling	Blurred vision	Flashing lights	Crossed / lazy eyes
Dryness	Eye pain / soreness	Double vision	Glare / sensitivity to light

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any change in my medical status I will inform the doctor.

I authorize my insurance company to pay the doctor or medical group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

I understand that payment is due in full at time of treatment, unless prior arrangements have been approved.

Signature _____ Date _____