PATIENT INFORMATION SHEET
The Office of Dr. Todd E. Wright
Stonebridge Eye Care

Last Name:	First:	Middle:
Preferred Name:	Gender: M F	Marital Status: S M D W
Spouse's Name (if applicable):	Parent/Guardian's Names (if minor):	
Address:		Apt # :
City:		
State: ZIP:		
Date of Birth: / /	Age:	Social Security #: / /
Height:	Weight:	Eye Color:
Home Phone: ( ) Work Phone: ( ) Cell Phone: ( )	OK TO TEXT ABOUT APPOINTMENTS/ORDERS: ________________ PLEASE INITIAL HERE	
E-mail:	Race: Amer. Indian Arabic Asian Afr. Amer Latino-Hisp. Hawaiian-Pac Islander Caucasian	
Employer/Position:	Ethnicity: Latino-Hispanic African. Amer. White	
Students: School (grade)	University/College:	
Emergency Contact: Relationship:	Phone Number: ( )	
Primary Care Physician and Phone Number:	Last Physical Exam:	
Pharmacy Name/Location:		
How did you learn about our office? Is there someone we can thank?		
List family members who are patients here:		

Eye Examination History

Date of Last Eye Exam:	Name of Last Eye Doctor:	Would you like help in selecting new eyewear today? YES NOT TODAY
Do You Wear Eyeglasses? YES NO Part-Time	Type of Glasses? Reading Driving Computer Hobby Sports Sunglasses	Are You Interested In LASIK ? YES NO Not Sure
Do You Wear Contact Lenses? YES NO Part-Time	What Type of Contact Lenses? Brand Name of Contact Lenses:	What Contact Lens Solutions Do You Use?

Name: ______________________________

GENERAL AND EYE HEALTH HISTORY

Please CHECK next to those conditions, symptoms or eye surgeries that apply to YOU.

✓		
Blindness	Blurred Vision	High Blood Pressure
Crossed Eyes	Itchy Eyes	Migraines
Dry Eyes	Eye Fatigue	Prostate Disorder
Droopy Eyelids	Floaters	Raynaud's Disease
Floaters/Flashes	Flashing Lights	Rheumatoid Arthritis
Glaucoma	Loss of Vision	Requires Wheelchair
Infections of the Eyes	Redness	Sarcoidosis
Light Sensitivity	Watery Eyes	Sickle Cell Disease
Macular Degeneration		Sjogren's Syndrome
Retinal Tear/Detachment	Alzheimer's or Dementia	Sleep Apnea
	Allergies	Stroke
Cataract Surgery	Anemia	Thyroid Disease
Corneal Surgery	Cancer	Ulcerative Colitis
Eyelid Surgery	Type:	Vertigo
Eye Muscle Surgery	Carotid Artery Disease	
Glaucoma Surgery	COPD	FEMALES ONLY---
LASIK PRK RK	Diabetes Type 1	Are you pregnant? YES NO
Macular Degeneration Surgery	Diabetes Type 2	Are you nursing? YES NO
Retinal Surgery	Heart Disease	
Diabetes Laser Surgery	Hearing Loss	

CURRENT MEDICATIONS BEING USED (PLEASE INCLUDE OVER-THE-COUNTER) AND ANY EYE DROPS USED

WHAT MEDICATIONS ARE YOU **ALLERGIC** TO? PLEASE LIST THEM HERE:

____

Please check conditions which CLOSE FAMILY MEMBERS HAVE and their relationship to you:

✓	
Blindness	Retinal Detachment
Dry Eye	Heart Disease
Glaucoma	Stroke
Keratoconus	Diabetes
Macular Degeneration	Cancer

SOCIAL HISTORY

Do you smoke? YES No How many packs a day? _________ Are you a previous smoker? YES NO
Do you use alcohol? YES No Drinks per day: _________
Do you drive? YES NO

MAJOR MEDICAL AND VISION INSURANCE INFORMATION

Name ______________________________ **Date** ______________________

MAJOR MEDICAL INSURANCE INFORMATION

This information is required to complete any insurance claims on the patient's behalf. Information submitted here must be current, accurate, complete and legible in order for the appropriate claim to be submitted. If you have any questions about completing this section, please ask the front desk staff member for assistance.

(this information is required and must be correct in order for our office to file your claim)

Major Medical Insurance	Insured ID	Group #
Member's Full Name	**Member's Birthdate**	**Relationship to Insured**
Member's Address	**Member's Phone** ( )	**Member's Employer**

VISION INSURANCE INFORMATION (if applicable)

(for information that is the same as above, write SAME in all correct boxes)

Vision Insurance Name	Insured ID	Group #
Member's Full Name	**Member's Birthdate**	**Relationship to Insured**
Member's Address	**Member's Phone** ( )	**Member's Employer**

I HAVE COMPLETED THIS INFORMATION PACKET AND UNDERSTAND THAT INCORRECT OR FALSE INFORMATION MAY RESULT IN UNPAID CLAIMS. I UNDERSTAND THAT I AM RESPONSIBLE FOR UNPAID CLAIMS. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT AT THE TIME SERVICES ARE RENDERED AS WELL AS APPLICABLE COPAYMENTS AND FEES APPLIED TO DEDUCTIBLES. I AGREE TO PAY FOR ALL BILLED SERVICES AND MATERIALS TODAY. I UNDERSTAND THAT I AM RESPONSIBLE FOR SERVICE AND MATERIAL FEES IF DR. WRIGHT IS NOT A PROVIDER FOR MY INSURANCE. I UNDERSTAND THAT IF I AM THE RESPONSIBLE PARTY FOR A MINOR PATIENT THAT ALL OF THE ABOVE SAID STATEMENTS ARE MY RESPONSIBILITY. MY SIGNATURE BELOW INDICATES I HAVE READ AND AGREE TO THESE STATEMENTS REGARDING THE BILLING AND PAYMENT FOR MY CARE AND SERVICES PROVIDED AT THIS OFFICE.

Responsible party Signature ______________________________ **Date** ______________________

Acknowledgement of Receipt of Privacy Policy

I received and understand the Privacy Policy of this office regarding the protection and security of my personal health information.

Name ____

Date ________________

Permission to Share Personal Health Information

Listed below are the names and phone numbers of individuals for whom I am giving permission to access information or materials from this office which pertain to me, my health status, my personal health record and all other information contained within this office or its electronic data base.

(Our office is required to offer this option and to abide by your wishes.)

Name	Phone Number	Date Permitted	Date Removed

Patient Signature ____ Date____________