Bay Ridge Family Eyecare Patient Information

PLEASE PRINT **Today's Date:** _____

Last Name: _____ **First Name**: _____

Date of Birth: _____ **Gender (circle)**: Male or Female

Social Security Number: _____-_____-_____

Address: _____ **Apt** _____

City/State/ZIP:_____ **E-mail**:_____

Telephone Number:_____ **Cell Number:**_____

Type of Insurance:_____ **Relationship to Insured**: Self/ Spouse/Child

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Marital Status: (please circle one): Single Married Divorced Widowed

Employment Status (please circle one): Full-time employed - Part-time employed - Full-time student Part-time student - Unemployed - Retired- **Occupation (if applicable):**_____

Preferred language: English Spanish Other:_____

Race: White - Hispanic - Asian - African American - Native American

Ethnicity: Hispanic/Latino - Not Hispanic/Latino - Native Hawaiian

Communication preference: E-mail - Postal - Telephone Text message

Primary Doctor Name:_____

Address: _____**Phone**_____

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protect health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is acknowledgement that you have received this notice of privacy practices:

Print Name: _____Signature: _____Date: _____

Bay Ridge Family Eyecare Questionnaire

Do you smoke or use tobacco? Never smoked_____ Former smoker_____ YEAR STOPPED_____

If Current smoker. Estimated packs/day: _____ YEAR STARTED_____

Bay Ridge Family Eyecare recommends discontinuation of all tobacco products.

- Please list all **PRESCRIPTION MEDICATIONS** you are taking (including all eye drops):

_____

_____

- Do you have any **ALLERGIES** to any medication? Yes or No If yes, please list:_____

Do you currently have of the following MEDICAL CONDITIONS?

If Yes, please provide as much detail as possible (type, treatment and/or surgery received, etc).

Please mark Y or N:	Yes	No	Details
GLAUCOMA	___	___	_____
MACULAR DEGENERATION	___	___	_____
CATARACT	___	___	_____
DIABETES	___	___	_____

If yes, please provide your doctor's Name _____

Address _____ Phone _____

HIGH BLOOD PRESSURE	___	___	_____
HEART DISEASE	___	___	_____
THYROID DISEASE	___	___	_____
ASTHMA	___	___	_____
PSYCHIATRIC (anxiety, depression etc.)	___	___	_____
CANCER	___	___	_____
SINUS PROBLEMS	___	___	_____
OTHER	___	___	_____

Has anyone in your FAMILY had the following diseases? Please circle and state relation to you.

[glaucoma, diabetes, high blood pressure, heart condition, stroke, cancer, thyroid, etc.]

_____

Does your vision limit any activities of your daily living (driving, reading, sports etc.) Yes or No

Are you pregnant or think you might be pregnant? Yes or No **Are you bothered by sunlight/glare?** Yes or No

Date of Last eye exam: _____

What is/are the reason(s) for your visit today? Glasses , Contacts Other: _____