



Milwaukie Family Eye Care
2306 SE Washington Street Milwaukie, Oregon 97222
Office: 503.654.3212 • Fax: 503.652.2460
familyeyecaremilw@gmail.com • www.milwaukiefamilyeyecare.com

PATIENT INFORMATION FORM

PERSONAL INFORMATION

Title: [] Mr. [] Mrs. [] Ms. [] Miss [] Master Today's date: _____

Full name: _____ Date of Birth: ___/___/___ Age: _____ Sex: [] M [] F

Billing address: _____

City: _____ State: _____ Zip: _____ E-mail address: _____

Home phone: () _____ Work number: () _____ Cell phone: () _____

Primary Care Physician: _____ PCP phone number: () _____

Marital Status: [] Single [] Married [] Separated [] Divorced [] Widowed

Spouse: _____

Ethnicity: (circle one) Caucasian Black Asian Latino American Indian Pacific Islander Other _____

Preferred name: _____ Preferred Language: _____

Person responsible for bill: _____

Communication preference: [] Phone [] Text [] Email

PRIMARY INSURANCE INFORMATION

Name of Primary Insurance Company: _____

Policy Holder's Full Name: _____ Policy Holder's Date of Birth: ___/___/___

Patient's relationship to Policy Holder: _____

Insurance Identification Number : _____ Group Number: _____

CONSENT FOR TREATMENT AND COMMERCIAL ASSIGNMENT OF BENEFITS

I am either the patient who is seeking treatment or I am the person who is authorized to seek treatment for the patient. I consent to medical treatment and diagnostic procedures as provided by Milwaukie Family Eye Care, its associated physicians, clinicians, and other personnel. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination at Milwaukie Family Eye Care.

I authorize the release of any medical or other information necessary to process any claims on my behalf. I also request payment of government or medical benefits either to myself or to the party who accepts assignment. I understand and agree that I am financially responsible to Milwaukie Family Eye Care for charges not paid under my policy. All copays and non-covered charges are due at the time of service. I permit a copy of this authorization to be used in place of the original.

THE UNDERSIGNED CERTIFIES THAT EACH HAS READ AND UNDERSTANDS THE ABOVE TERMS AND CONDITIONS.

PATIENT SIGNATURE

PATIENT'S REPRESENTATIVE SIGNATURE

DATE

MEDICAL HISTORY QUESTIONNAIRE

This form is critical for the doctor to thoroughly evaluate your vision and health. Please completely fill out both sides. Thank you!

Name: _____ Date: ____/____/____ Birth date: ____/____/____

PERSONAL MEDICAL HISTORY

Last Medical Exam: ____/____/____ Name of Family Physician _____

List all major injuries, surgeries and/or hospitalizations: _____

Are you currently being treated for any of the following?

Arthritis: Yes No Family

Heart Disease : Yes No Family

Diabetes : Yes No Family

Stroke: Yes No Family

High Blood Pressure: Yes No Family

Other: _____

List any medications you are currently taking (include oral contraceptives, aspirin, etc.) _____

Do you have allergies to medications? Yes No If yes, please list: _____

If female, are you currently pregnant? Yes No

Do you smoke? Yes No If yes, type/amount per week: _____

Do you drink alcohol? Yes No If yes, type/amount per week: _____

DISEASE/CONDITION

EYE HISTORY

Blurred Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dryness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Itching	<input type="checkbox"/> Yes <input type="checkbox"/> No
Burning	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lazy Eye	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Flashes of light	<input type="checkbox"/> Yes <input type="checkbox"/> No	Light Sensitivity	<input type="checkbox"/> Yes <input type="checkbox"/> No
Crusting on Eyelid	<input type="checkbox"/> Yes <input type="checkbox"/> No	Floating dark spots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Macular Degeneration	<input type="checkbox"/> Yes <input type="checkbox"/> No
Decreased Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Foreign Body Sensation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Redness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Discharge	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Retinal Tear/Detachment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Double Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Halos	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sandy/gritty feeling	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drooping Eyelid	<input type="checkbox"/> Yes <input type="checkbox"/> No				

Past Eye Surgeries? Yes No Type: _____ Date: _____

Past Eye Injuries? Yes No Type: _____ Date: _____

Other: _____

Do you currently wear glasses? Yes No Contact lenses? Yes No Neither

FAMILY OCULAR HISTORY (i.e. Glaucoma, Macular Degeneration, Diabetic Retinopathy)

RELATIVE	AGE	EYE DISEASE
Father	_____	_____
Mother	_____	_____

REVIEW OF SYSTEMS

Are you currently experiencing problems with any of the following?

SYSTEM			EXPLAIN/MEDICATIONS
• Sudden weight gain or loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
• Chronic fever or chronic fatigue	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
• Heart <i>(example: chest pain, angina, irregular heart beat)</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
• Respiratory <i>(example: coughing, wheezing, shortness of breath, asthma)</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
• Ear/Nose/Throat <i>(example: sore throat, sinus problems, earache, hearing loss)</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
• Gastrointestinal <i>(example: abdominal pain, heartburn, bowel problems, vomiting)</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
• Urinary <i>(example: pain when urinating, blood in urine)</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
• Hematologic/Lymphatic <i>(example: blood disorders, bruising, cuts heal slowly, enlarged glands)</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
• Endocrine <i>(example: thyroid problems)</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
• Integumentary <i>(example: rashes, dry skin)</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
• Musculoskeletal <i>(example: joint pain, stiffness or swelling, muscle pain)</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
• Neurological <i>(example: numbness, headache, seizures, paralysis)</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
• Psychiatric <i>(example: depression, anxiety, insomnia, confusion)</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
• Allergic/Immunologic <i>(example: reaction to food or drugs, allergies, hay fever)</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

REVIEWED BY PATIENT AND CHANGES AS INDICATED:

Patient's Signature: _____

Patient's Signature: _____

Patient's Signature: _____

Patient's Signature: _____

Patient's Signature: _____

Patient's Signature: _____

Patient's Signature: _____

Patient's Signature: _____

Patient's Signature: _____

Patient's Signature: _____

PHYSICIANS SIGNATURE

Date: ___/___/___

Date: ___/___/___

Date: ___/___/___

Date: ___/___/___

Date: ___/___/___

Date: ___/___/___

Date: ___/___/___

Date: ___/___/___

Date: ___/___/___

Date: ___/___/___