Patient Information

Victor A. Crosby, M.D.

Personal Information:

Dr. Mr. Mrs. Miss. Ms:_____Date:_____

Date of Birth:_____ Age: _____ M/F_____

Mailing Address:_____City:_____State:_____Zip:_____

Home Phone: (_____)_____Work Phone: (_____)_____

Cell Phone: (_____)_____ Email Address:_____

OK to to contact by E-mail?_____ or Text:_____

Occupation:_____ Employer:_____

Address:_____ City:_____State:_____Zip:_____

Are you?: (please circle one) Minor Single Married Widowed Divorced

Spouse Name:_____ Work Phone:_____

Referred By: Doctor Name: _____ Friend:, Relative or Website (name):_____

Primary Care Physician :_____ Phone:_____

Name of Parent/ Guardian(or Caregiver):_____

Address:_____City_____ State:_____ Zip:_____

Home Phone:_____ Work phone:_____

Insurance Information: *Present card to front office staff.*

Are you personally responsible for payment of your fees? YES_____ NO_____ If No , who is?

Name:_____ Relationship:_____

Address:_____ City:_____State:_____Zip:_____

Home Phone:_____Work or Cell Phone:_____

Who to notify in case of emergency?_____Phone:_____

Financial Assignment and Agreement:

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-pay insurance, or any other balance not paid for by your insurance.
2. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
3. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorized said assignee to release all information necessary to secure the payment.

Patients and/or Guardian Signature:_____**Date:**_____

PATIENT MEDICAL HISTORY RECORD

PATIENT'S NAME SEX AGE

EYE HISTORY

Thank you for choosing our office for your eye care. To better serve you, please answer the following questions:

1. Do you wear glasses? **yes** _____ **no** _____

2. Do you wear contact lenses? **yes** _____ **no** _____

3. Do you have problems reading? **yes** _____**no** _____

4. Are you currently experiencing any eye symptoms? Please circle all that apply:

Eye Pain Blurred Vision Eyelid Crusting Flashes of light Halos Floaters

Discharge Light Sensitivity Double Vision Decreased Vision

5. Have you ever had an eye injury? Please describe:_____

6. Have you ever had eye surgery? Please list type, which eye, and approximate dates:
_____

Please answer the following questions about your medical status and history:

1. Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, arthritis, etc.)
_____**YES** _____**NO** IF **YES**, please explain: _____
2. Have you ever had any eye disease (e.g., glaucoma, cataract, wandering, or "lazy" eye, retinal detachment)?
_____**YES** _____**NO** IF **YES**, please explain:_____

3. Have you ever had any surgery? _____**YES** _____**NO** IF **YES**, please provide date and reason:
_____
_____

4. Have you ever been hospitalized? _____**YES** _____**NO** IF **YES**, please provide date and reason:
_____
_____

5. Do you take ANY medications? _____**YES** _____**NO** IF **YES**, please list:_____
_____

Do you use any eye medications? _____**YES** _____**NO** IF **YES**, please list:_____

6. Do you have any drug or food allergies? _____**YES** _____**NO** IF **YES**, please list:_____
_____

Family and Social History

Do any medical or eye diseases run in your family (e.g., diabetes, high blood pressure, cancer, glaucoma, or macular degeneration)? _____**YES** _____**NO** IF **YES**, please explain:_____
_____

Do you smoke? _____**YES** _____**NO** IF **YES**, how much?_____

Do you drink alcohol? _____**YES** _____**NO** IF **YES**, how much?_____

Do you or have you ever used recreational drugs? _____**YES** _____**NO** IF **YES**, type and when:_____

If employed, how many hours a week do you work?_____

_____ _____
Signature Date

11/18