EYE Wisconsin Intake

EYE Wisconsin Intake Form

1. Patient Information:

Title: ○ Dr. ○ Mr. ○ Mrs. ○ Ms.

Last Name: ____________

First Name: ____________

Middle Initial: ____________

Preferred Name: ____________

Date of Birth: ____________

Gender: ○ Male ○ Female

Address: ____________

Apt./Unit #: ____________

Social Security #: ____________

Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed

Home Phone: ____________

May we leave a message on your phone? ○ Yes ○ No

Cell Phone: ____________

May we leave a message on your phone? ○ Yes ○ No

Daytime Phone: ____________

May we leave a message on your phone? ○ Yes ○ No

Email Address: ____________

May we contact you via email? ○ Yes ○ No

2. Emergency Contact:

Name: ____________

Phone: ____________

3. If patient is a minor:

Guardian Name: ____________

Relationship: ____________

Phone: ____________

4. Insurance Information:

Primary Insurance: ____________

ID #: ____________

Insured's Name: ____________

Date of Birth: ____________

SSN #: ____________

Relationship to insured: ○ Self ○ Spouse ○ Dependent

Employer's Name: ____________

5. Secondary Insurance: ______ ID #: ______

Insured's Name: ______ Date of Birth: ______ SSN #: ______

Relationship to insured:
○ Self ○ Spouse ○ Dependent

Family History Information

6. Have any of your blood relatives, living or deceased, had any of the following conditions.

	YES	NO
Glaucoma		
Cataract		
Crossed Eyes		
Macular Degeneration		
Retinal Disease/Detach		
Blindness		
Cancer		
Diabetes		
High Blood Pressure		
Heart Disease		
Kidney Disease		

Referral

7. How did you hear about us?

- ☐ Insurance list
- ☐ Sign/Marketing
- ☐ Phonebook
- ☐ Website
- ☐ Friend/Family

If Friend/Family, please specify:

______

Personal Medical/Ocular History Form

8. What is the name of your primary care physician?

______

Medical History

9. Have you ever been diagnosed with any of the following:

	YES	NO
Diabetes		
High Blood Pressure		
Heart Disease		
High Cholesterol		
Kidney/Liver Disease		
Hypo/Hyperthyroidism		
Cancer		
Stroke		

10. Do you take any medications on a regular basis?

- Yes
- No

11. If yes, please list:

	Medication Name	Dosage	Frequency	Reason for Taking
1				
2				
3				

12. Do you have allergies to medication?

- Yes
- No

13. If yes, please list:

	Medication Name	Reaction
1		
2		
3		

14. Do you smoke?

- Yes
- No

15. Do you drink alcohol?

- Yes
- No

16. Are you pregnant/nursing?

- Yes
- No

Ocular History

17. Who performed your last eye exam? ______________________ When: ______________

18. Have you ever been diagnosed with any of the following:

	YES	NO
Glaucoma		
Cataracts		
Corneal Disease		
Macular Degeneration		
Retinal Disease/Detach		
Crossed Eyes		

19. Have you ever had surgery on your eyes?

- Yes
- No

20. If yes, please list:

____

21. Please list all eye medications:

____

____

____

____

22. What is the reason for your visit today?

	YES	NO
Distance vision blur		
Near vision blur		
New contact lenses		
New glasses		
Glaucoma		
Cataracts		
Red Eyes		
Painful Eyes		

23. How old are your current glasses?

____

24. If you wear contacts, what brand?

____

25. Are you satisfied with them?

- ○ Yes
- ○ No

26. Please list name of any specific individuals to whom we may release personal and medical/vision information:

____
____
____
____