MOBERLY EYE CENTER
David M. Whitson, O.D.
OPTOMETRIST

PATIENT INFORMATION (Please print information about the patient here.)

TODAYS DATE: ______________________ HOME PHONE ______________________ Cell ______________________

PATIENT'S NAME ______________________ DATE OF BIRTH ___/___/___
FIRST MIDDLE LAST

ADDRESS ______________________
STREET CITY STATE ZIP

SOCIAL SECURITY NUMBER ______________________ SEX ______ MARITAL STATUS ______________________

EMPLOYER ______________________ OCCUPATION ______________________

WORK PHONE ______________________ MAY WE CONTACT YOU AT WORK? _____YES _____NO

EMAIL ADDRESS ______________________ MAY WE TEXT YOU APPOINTMENT REMINDERS Y/N

COMPLETE THIS SECTION ONLY IF SOMEONE OTHER THAN THE PATIENT IS FINANCIALLY RESPONSIBLE.

NAME ______________________
FIRST MIDDLE LAST

RELATION TO PATIENT ______________________ DATE OF BIRTH ___/___/___

ADDRESS ______________________ PHONE(____) ______________________
STREET CITY STATE ZIP

SOCIAL SECURITY NUMBER ______________________ EMPLOYER ______________________

EMERGENCY INFORMATION (Who could we contact in case of emergency or if we can't reach you?)

NAME ______________________ RELATION ______________________ PHONE(___) ______________________

ADDRESS ______________________ BUSINESS PHONE(____) ______________________

INSURANCE INFORMATION (Please print information about the patients insurance coverage here.)

PRIMARY CARRIER: Insurance Company ______________________ ID Number ______________________

Insured's Name ______________________ GroupNumber ______________________

Insured's Date of Birth ______________________ Relation to Patient ______________________

SECONDARY CARRIER: Insurance Company ______________________ ID Number ______________________

Insured's Name ______________________ Group Number ______________________

Insured's Date of Birth ______________________ Relation to Patient ______________________

LIST ANY SPECIAL HOBBIES OR INTERESTS YOU MAY HAVE:

___Carpentry ___Hunting/Shooting ___Golfing ___Racquet Sports ___Baseball/Softball

Other: ______________________

PLEASE SEE BACK FOR ADDITIONAL INFORMATION

Revised 11/02

MEDICAL HISTORY(Please carefully read and check any of the conditions which apply to you)
DO YOU NOW HAVE OR HAVE YOU EVER HAD ANY OF THE PROBLEMS LISTED BELOW?

___Lazy Eye(s)	___Glare	___Chronic Bowel Disease	___Thyroid/Other Glands
___Blurred Vision	___Light Sensitivity	___Allergies	___Anemia/Bleeding Disorder
___Distorted Vision	___Flashes/Floaters	___Cancer	___Depression
___Loss of Side Vision	___Eye Injuries	___High Blood Pressure	___Genitals/Kidney/Bladder
___Double Vision	___Eye Surgeries	___Heart Disease	___Headaches/Migraines
___Redness/Irritation	___Fever, Weight Loss/Gain	___Diabetes	___Seizures
___Eye Pain	___Respiratory/Breathing Disorder	___Eczema/Psoriasis	___Stroke

___Other:______________________________

____

FAMILY HISTORY: Please check the medical conditions that any family member (parents, grandparents, siblings, children)experienced:

___Blindness	___Cataracts	___Lazy Eyes
___Glaucoma	___Macular Degeneration	___Retinal Detachment/Disease
___Arthritis	___Cancer	___Diabetes
___Heart Disease	___High Blood Pressure	___Kidney Disease
___Lupus	___Thyroid Disease	___Other______________________________

HAVE YOU TESTED POSITIVE FOR ANY OF THE FOLLOWING: HIV___ CMV___ TB___Hepatitis___

ARE YOU TAKING ANY MEDICATIONS NOW? ___NO ___YES If yes, please list medications below:

____

____

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? ___NO ___YES If yes, please explain:

____

DO YOU USE : Tobacco Products Y/N Alcohol Y/N How much?______________ Illegal Drugs?______________

Patient Signature: ______________________________ **Date:** ____________________
(Parent/Guardian Signature if patient is a minor)