TRIAD EYE INSTITUTE

Patient Name: _____

DOB: _____ **Age:** _____ **SSN:** _____

Birth Gender: Male Female Declined

Gender Identity: Declined Male Female Male-to-female/ transgender female Female-to-male/ transgender male Genderqueer, neither exclusively male nor female Additional gender category or other:

Sexual Orientation: Declined Bisexual Lesbian, gay or homosexual Don't Know Straight or heterosexual Other:

Address: _____

City: _____ **State:** _____ **Zip:** _____

Marital Status: Divorced Domestic Partner Legally Separated Life Partner Married Single Widowed

Spouse's Name: _____ **Spouse's DOB:** _____

Spouse Employer: _____

Race: Black or African American American Indian or Alaska Native Asian
Native Hawaiian or other Pacific Islander Other Race White Decline to specify

Ethnicity: Not Hispanic or Latino Declined to specify Hispanic or Latino Other Unknown

Preferred Language: English Spanish Decline to specify

Primary Care Physician Name: _____

Home Phone: _____ **Cell Phone:** _____

Email Address: _____

Preferred method of contact: Home Cell Work

May we have permission to leave medical information on your voice mail? No Yes

May we text you appointment reminders? No Yes

Employment / Student Status: _____

Employer: _____ **Work Phone:** _____

Emergency Contact

Name: _____ **Phone:** _____

Address: _____ **Relationship to Patient:** _____

TRIAD EYE INSTITUTE

Person Responsible for Payment (if same as patient leave blank)

Name: _____ **DOB:** _____ **Relation to Patient:** _____

SSN: _____ **Employer:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Insurance Information

Primary Insurance Company Name: _____ **Address:** _____

Policy Number: _____ **Group Number:** _____

Subscriber Name: _____ **DOB:** _____ **Relation to Patient:** _____

Secondary Insurance Name: _____ **Address:** _____

Policy Number: _____ **Group Number:** _____

Subscriber Name: _____ **DOB:** _____ **Relation to Patient:** _____

Additional Information

How were you referred to us today? Family, Eye Doctor, PCP, Friend, Other: _____

Who is your current eye doctor? _____ **Date of last visit:** _____

May we request your previous vision records? _____

Do you currently reside in a skilled nursing facility? _____ **If Yes, facility name:** _____

Do you have a power of attorney? _____

Are you currently receiving Hospice care? Y/N

Preferred Pharmacy and e-Prescribing Consent

I agree that Triad Eye Institute may request and use my prescription medications history from other healthcare providers or third-party pharmacy benefits payers for treatment purposes.

Patient Signature: _____ **Date:** _____

Preferred Pharmacy: _____ **City:** _____ **Phone:** _____

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of Triad Eye Institute's notice of privacy practices. I also give permission to Triad Eye Institute to release my protected health information to the following people, if requested by such:
(list names in the spaces provided)

_____ _____ _____ _____

Print Name: _____ **Signature:** _____ **Date:** _____

Patient Name: _____ DOB: _____

Height: _____ Weight:: _____

Reason for your visit?

Eye History: (Check all that apply)

☐Dryness ☐Floaters **Do you currently wear?**

☐Irritation ☐Tearing ☐Glasses

☐Itching ☐Retinal Detachment ☐Contacts:

☐Decreased Vision ☐Cataracts ☐Soft or ☐RGP (Hard) Last Worn:

Past Medical History:

☐Thyroid Disease ☐High Blood Pressure ☐Diabetes:

☐Heart Disease ☐Hepatitis Type: ☐Type 1 ☐Type 2

☐Glaucoma ☐Macular Degeneration ☐Insulin ☐Non-Insulin

☐HIV ☐None BS: _____ Time: _____

☐TB Yr. Diagnosed. _____ Active: ☐ Yes ☐ No Last A1C: _____ Date: _____ Yr. Diag: _____

Influenza Immunization Received? ☐Yes ☐No If yes date received: _____

Pneumococcal Vaccination Received? ☐Yes ☐No If yes date received: _____

List any other past medical conditions not listed above: _____

Have you had any of the following eye surgeries? List the year the surgery was performed and what doctor performed the procedure

☐Cataracts	Doctor:	Year:		☐RK	Doctor:	Year:	
☐RLE	Doctor:	Year:		☐LASIK	Doctor:	Year:	
☐YAG Laser	Doctor:	Year:		☐Corneal	Doctor:	Year:	
☐PRK	Doctor:	Year:		☐ICL	Doctor:	Year:	
☐Other:				☐None			

Medications list any medications and dosage: (including non-prescription)

Medication Allergies

Are you allergic to any medication? (if yes, please list medication name and reaction) ☐Yes ☐No

Medication: **Reaction:**

Preferred Pharmacy:

Family History

Do you have any family history of the following? (If yes, please note the relationship to the patient)

☐Glaucoma Mother, Father, Sibling, Grandparent ☐High Blood Pressure Mother, Father, Sibling, Grandparent

☐Diabetes Mother, Father, Sibling, Grandparent ☐Macular Degeneration Mother, Father, Sibling, Grandparent

Social History

Smoking Status ☐Current ☐Never ☐Former

Alcohol Use ☐Never ☐Rarely ☐Moderate ☐Daily

Fall Risk ☐No ☐Yes ☐Patient not ambulatory

Review of Systems

Do you have any of the following TODAY? (Check all that apply)

Gastrointestinal	☐Heartburn / Reflux	☐Nausea / Vomiting / Diarrhea		☐None
HENT	☐Hay fever / Allergies / Congestion	☐Sinusitis	☐Neck Problems	☐None
Cardiovascular	☐Chest Pains / Discomfort	☐Palpitations		☐None
Neurological	☐Headaches/ Migraines	☐Weakness		☐None
Respiratory	☐Cough / Wheeze	☐Shortness of Breath		☐None
Musculoskeletal	☐Muscle/ Joint Pain	☐Swollen Joints		☐None
Genitourinary	☐Leaking Urine	☐Bloody Urine		☐None
Psychiatric	☐Anxiety / Stress	☐Depression	☐Psychiatric illness	☐None
Blood/ Lymphatic	☐Blood Disease	☐Unexplained Lumps		☐None
Integumentary	☐Rash			☐None
Female Only: Are you currently pregnant or nursing?		☐Yes	☐No	