The Office of Dr. Todd E. Wright
Stonebridge Eye Care

Mr /Ms/Mrs/Dr	Last Name:	First Name:	Middle Name:
Preferred Name:		Gender: M F	Marital Status: S M D W
Spouse's Name (if applicable):		Parent's or Guardian's Names (if minor):	

Address:	Apt # :
City:	
State: ZIP:	

Date of Birth: / /	Age:	Social Security #: / /
Height:	Weight:	Eye Color: BL BR GR HZ Not sure
Home Phone: ( )	Cell Phone: ( )	Work Phone: ( )

E-mail:	Preferred Language: English Spanish Other:
Employer:	Race: Amer. Indian Asian Afr. Amer Latino-Hisp. Hawaiian-Pac Islander Arabic Caucasian
Position:	Ethnicity: Latino-Hispanic African. Amer. White Arabic Other
For Students - School/Univ or Grade::	Preferred Communication From Our Office (circle all that apply): Text Message Email Cell Phone Home Phone US Mail
I WOULD LIKE TO RECEIVE APPOINTMENT REMINDERS BY TEXT MESSAGE OR EMAILS. I UNDERSTAND THAT THERE MAY BE CHARGES TO MY PHONE BILL DEPENDING ON MY PHONE MESSAGING PLAN. PLEASE PLACE INITIALS IN BOX INDICATING THIS IS APPROVED---------->	INITIAL HERE:
Emergency Contact:	Phone Number: ( ) Relationship:
Primary Care Provider and Phone Number:	Last Physical Exam:
Preferred Pharmacy:	Pharmacy Phone Number: ( )
How did you learn about our office?	Name of Person Who Referred You Here:
List family members who are patients here:	

Eye Examination History

Date of Last Eye Exam:	Name of Last Eye Doctor:	Would you like help in selecting new eyewear today? YES NOT TODAY
Do You Wear Eyeglasses? YES NO Part-Time	Type of Glasses? Reading Driving Computer Hobby Sports Sunglasses	Are You Interested In LASIK ? YES NO Not Sure
Do You Wear Contact Lenses? YES NO Part-Time	What Type of Contact Lenses? Soft Rigid 1 Day Disp 2 Week 1 month 3 Month Brand Name of Contact Lenses:	What Contact Lens Solutions Do You Use?

EYE HEALTH HISTORY

Crossed Eyes		Lazy Eye		Droopy Eyelids		Glaucoma	
Macular Degeneration		Cataracts		Retinal Detachment		Dry Eye	
Eye Infections		Herpes of the Eye		Fuch's Dystrophy		Keratoconus	
Light Sensitivity		Watery Eyes		Floaters		Eye Allergies	
Cataract Surgery		Lid Surgery		Retina Surgery		Eye Muscle Surgery	
LASIK / PRK (circle one)		RK		Glaucoma Surgery		Eye Injury	

GENERAL HEALTH HISTORY

PLEASE LIST ALL CURRENT MEDICATIONS BEING USED

EYE DROPS CURRENTLY BEING USED

ALLERGIES TO MEDICATIONS

Female Patients Only : Pregnant or Nursing

Are you pregnant? YES NO	Are you nursing? YES NO

PLEASE CAREFULLY CHECK (X) CONDITIONS WHICH YOU HAVE OR HAVE HAD

Anemia		Depression		Concussions		Headaches		Diabetes Type 1		IBS	
Leukemia		Anxiety		Hearing Loss		Migraine HA		Diabetes Type 2		Crohn's Disease	
Sickle Cell		Bi-Polar Disorder		Vertigo		Ocular Migraine		Hypoglycemia		Fibromyalgia	
Myeloid Disease		Carotid Artery Disease		Tinnitus (Ringing)		Sarcoidosis		Kidney Disease		Acne	
Lymphoma		Heart Disease		Seasonal Allergies		Dermatomyositis		Thyroid Disease		Hives/Rashes	
Osteoporosis		High Blood Pressure		Asthma		Lupus		Prostate Enlargement		Skin Cancer	
Cancer type:		Pacemaker		Emphysema		Sjogren's Syndrome		Prostate Cancer		Other?	
Rheumatoid Arthritis		Seizures		COPD		HIV +		STD? Type:		Other?	
Osteogenesis Imperfecta		Multiple Sclerosis		Sleep Apnea		Raynaud's Disease		Ulcerative Colitis		Other?	
Fever Blisters		Stroke		Bronchitis		Hepatitis Type _____		Requiring a wheelchair		Other?	

FAMILY MEDICAL HISTORY / PLEASE RECORD FAMILY MEMBER

High Blood Pressure	Diabetes	Cancer (type)	Heart Disease	Arthritis
Macular Degeneration	Lazy Eye	Retinal Detachment	Glaucoma	Blindness

SOCIAL HISTORY

Do you smoke? YES NO	Do you use smokeless tobacco products? YES NO	Have you tried a tobacco use cessation program? YES NO
Do you drink alcohol? YES NO	Do you use illegal Drugs? YES NO	Do you drive a motor vehicle? YES NO

MAJOR MEDICAL AND VISION INSURANCE INFORMATION

Name _____ **Date** _____

MAJOR MEDICAL INSURANCE INFORMATION

This information is required to complete any insurance claims on the patient's behalf. Information submitted here must be current, accurate, complete and legible in order for the appropriate claim to be submitted. If you have any questions about completing this section, please ask the front desk staff member for assistance.

(this information is required and must be correct in order for our office to file your claim)

Major Medical Insurance	**Insured ID**	**Group #**
Member's Full Name	**Member's Birthdate**	**Relationship to Insured**
Member's Address	**Member's Phone** **( )**	**Member's Employer**

VISION INSURANCE INFORMATION

(for information that is the same as above, write SAME in all correct boxes)

Vision Insurance Name	**Insured ID**	**Group #**
Member's Full Name	**Member's Birthdate**	**Relationship to Insured**
Member's Address	**Member's Phone** **( )**	**Member's Employer**

I HAVE COMPLETED THIS INFORMATION PACKET AND UNDERSTAND THAT INCORRECT OR FALSE INFORMATION MAY RESULT IN UNPAID CLAIMS. I UNDERSTAND THAT I AM RESPONSIBLE FOR UNPAID CLAIMS. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT AT THE TIME SERVICES ARE RENDERED AS WELL AS APPLICABLE COPAYMENTS AND FEES APPLIED TO DEDUCTIBLES. I AGREE TO PAY FOR ALL BILLED SERVICES AND MATERIALS TODAY. I UNDERSTAND THAT I AM RESPONSIBLE FOR SERVICE AND MATERIAL FEES IF DR. WRIGHT IS NOT A PROVIDER FOR MY INSURANCE. I UNDERSTAND THAT IF I AM THE RESPONSIBLE PARTY FOR A MINOR PATIENT THAT ALL OF THE ABOVE SAID STATEMENTS ARE MY RESPONSIBILITY. MY SIGNATURE BELOW INDICATES I HAVE READ AND AGREE TO THESE STATEMENTS REGARDING THE BILLING AND PAYMENT FOR MY CARE AND SERVICES PROVIDED AT THIS OFFICE.

Patient Signature_____ **Date**_____

Acknowledgement of Receipt of Privacy Policy

Name _____

Date _____

_____

Permission to Leave Telephone Messages

◯ Please check this circle to give us permission to leave phone messages regarding your appointment times, requests for return calls or the status of orders pertaining to this office.

Initials: _____

Permission to Share Personal Health Information

Listed below are the names and phone numbers of individuals for whom I am giving permission to access information or materials from this office which pertain to me, my health status, my personal health record and all other information contained within this office or its electronic data base.

(Our office is required to offer this option and to abide by your wishes.)

Name	Phone Number	Date Permitted	Date Removed