PATIENT INFORMATION UPDATE
Stonebridge Eye Care
Dr. Todd E. Wright, OD

Last Name:	**First:**	**M.I.**	**DOB:**
Spouses Name (if applicable):	**Parent/Guardian's Name (if minor):**		
Address:		**Apt # :**	
City, State, Zip:			
Phone # :	**Email:**		
Preferred Pharmacy:			
Primary Care Physician:			
Employer/Occupation:	**School/Grade:**		

Medical Insurance:	**ID # :**	**Group # :**
Member's Full Name & DOB:		**Relationship to Insured:**
Member's Address:	**Member's Phone:**	**Member's Employer:**

I understand that incorrect or false information may result in unpaid claims and 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'm 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 initials below indicate I have read and agree to these statements regarding the billing and payment for my care and services provided at 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 it's electronic data base.

NAME **PHONE #** **RELATION**

_____

_____

I understand that by leaving this section blank, Stonebridge Eye Care will not be able to speak with/contact anyone besides myself regarding matters involving my personal health information. I understand that all listed individuals will have access until I revoke it verbally or in writing.

My signature indicates that information provided on this form is true and correct to the best of my knowledge.

_____ _____

Patient/Legal Guardian Signature **Date**

Name: _____

GENERAL AND EYE HEALTH HISTORY

Please CHECK next to those conditions, symptoms or eye surgeries that apply to YOU.

✓		
Blindness	Blurred Vision	High Blood Pressure
Crossed Eyes	Itchy Eyes	Migraines
Dry Eyes	Eye Fatigue	Prostate Disorder
Droopy Eyelids	Floaters	Raynaud's Disease
Floaters/Flashes	Flashing Lights	Rheumatoid Arthritis
Glaucoma	Loss of Vision	Requires Wheelchair
Infections of the Eyes	Redness	Sarcoidosis
Light Sensitivity	Watery Eyes	Sickle Cell Disease
Macular Degeneration		Sjogren's Syndrome
Retinal Tear/Detachment	Alzheimer's or Dementia	Sleep Apnea
	Allergies	Stroke
Cataract Surgery	Anemia	Thyroid Disease
Corneal Surgery	Cancer	Ulcerative Colitis
Eyelid Surgery	Type:	Vertigo
Eye Muscle Surgery	Carotid Artery Disease	
Glaucoma Surgery	COPD	FEMALES ONLY---
LASIK PRK RK	Diabetes Type 1	Are you pregnant? YES NO
Macular Degeneration Surgery	Diabetes Type 2	Are you nursing? YES NO
Retinal Surgery	Heart Disease	
Diabetes Laser Surgery	Hearing Loss	

CURRENT MEDICATIONS BEING USED (PLEASE INCLUDE OVER-THE-COUNTER) AND ANY EYE DROPS USED

WHAT MEDICATIONS ARE YOU ALLERGIC TO? PLEASE LIST THEM HERE:

_____

Please check conditions which CLOSE FAMILY MEMBERS HAVE and their relationship to you:

✓	
Blindness	Retinal Detachment
Dry Eye	Heart Disease
Glaucoma	Stroke
Keratoconus	Diabetes
Macular Degeneration	Cancer

SOCIAL HISTORY

Do you smoke? YES No	How many packs a day? _____ Are you a previous smoker? YES NO
Do you usé alcohol? YES No	Drinks per day: _____
Do you drive? YES NO	