Molalla Family Eye Care
502 East Main Street Molalla, Oregon 97038
Office: 503.829.9186 • Fax: 503.829.8402
molallafamilyeyecare@molalla.net • www.molallafamilyeyecare.com

PATIENT INFORMATION FORM

PERSONAL INFORMATION

Title: ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Master **Today's date:** _____

Full name: _____ **Date of Birth:** ___/___/___ **Age:** _____ **Sex:** ❑ M ❑ F

Billing address: _____

City: _____ **State:** _____ **Zip:** _____ **E-mail address:** _____

Home phone: ( ) _____ **Work number:** ( ) _____ **Cell phone:** ( ) _____

Primary Care Physician: _____ **PCP phone number:** ( ) _____

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Spouse: _____

Ethnicity: *(circle one)* Caucasian Black Asian Latino American Indian Pacific Islander Other _____

Preferred name: _____ **Preferred Language:** _____

Person responsible for bill: _____

Communication preference: ❑ Phone ❑ Text ❑ Email

PRIMARY INSURANCE INFORMATION

Name of Primary Insurance Company: _____

Policy Holder's Full Name: _____ **Policy Holder's Date of Birth:** ___/___/___

Patient's relationship to Policy Holder: _____

Insurance Identification Number : _____ **Group Number:** _____

CONSENT FOR TREATMENT AND COMMERCIAL ASSIGNMENT OF BENEFITS

I am either the patient who is seeking treatment or I am the person who is authorized to seek treatment for the patient. I consent to medical treatment and diagnostic procedures as provided by Molalla Family Eye Care, its associated physicians, clinicians, and other personnel. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination at Molalla Family Eye Care.

I authorize the release of any medical or other information necessary to process any claims on my behalf. I also request payment of government or medical benefits either to myself or to the party who accepts assignment. I understand and agree that I am financially responsible to Molalla Family Eye Care for charges not paid under my policy. All copays and non-covered charges are due at the time of service. I permit a copy of this authorization to be used in place of the original.

THE UNDERSIGNED CERTIFIES THAT EACH HAS READ AND UNDERSTANDS THE ABOVE TERMS AND CONDITIONS.

_____ _____ _____

PATIENT SIGNATURE **PATIENT'S REPRESENTATIVE SIGNATURE** **DATE**

MEDICAL HISTORY QUESTIONNAIRE

This form is critical for the doctor to thoroughly evaluate your vision and health. Please completely fill out both sides. Thank you!

Name:_____ **Date:** ____/____/_____ **Birth date:** ____/____/_____

PERSONAL MEDICAL HISTORY

Last Medical Exam: ____/____/____ **Name of Family Physician** _____

List all major injuries, surgeries and/or hospitalizations: _____

_____

Are you currently being treated for any of the following?

Arthritis:	❑ Yes	❑ No	❑ Family	**Heart Disease :**	❑ Yes	❑ No	❑ Family
Diabetes :	❑ Yes	❑ No	❑ Family	**Stroke:**	❑ Yes	❑ No	❑ Family
High Blood Pressure:	❑ Yes	❑ No	❑ Family	**Other:**	_____		

List any medications you are currently taking (include oral contraceptives, aspirin, etc.) _____

_____

Do you have allergies to medications? ❑ Yes ❑ No **If yes, please list:** _____

_____

If female, are you currently pregnant? ❑ Yes ❑ No

Do you smoke? ❑ Yes ❑ No **If yes, type/amount per week:** _____

Do you drink alcohol? ❑ Yes ❑ No **If yes, type/amount per week:** _____

DISEASE/CONDITION

EYE HISTORY

Blurred Vision	❑ Yes	❑ No	**Dryness**	❑ Yes	❑ No	**Itching**	❑ Yes	❑ No
Burning	❑ Yes	❑ No	**Eye Pain**	❑ Yes	❑ No	**Lazy Eye**	❑ Yes	❑ No
Cataracts	❑ Yes	❑ No	**Flashes of light**	❑ Yes	❑ No	**Light Sensitivity**	❑ Yes	❑ No
Crusting on Eyelid	❑ Yes	❑ No	**Floating dark spots**	❑ Yes	❑ No	**Macular Degeneration**	❑ Yes	❑ No
Decreased Vision	❑ Yes	❑ No	**Foreign Body Sensation**	❑ Yes	❑ No	**Redness**	❑ Yes	❑ No
Discharge	❑ Yes	❑ No	**Glaucoma**	❑ Yes	❑ No	**Retinal Tear/Detachment**	❑ Yes	❑ No
Double Vision	❑ Yes	❑ No	**Halos**	❑ Yes	❑ No	**Sandy/gritty feeling**	❑ Yes	❑ No
Drooping Eyelid	❑ Yes	❑ No						

Past Eye Surgeries? ❑ Yes ❑ No **Type:** _____ **Date:** _____

Past Eye Injuries? ❑ Yes ❑ No **Type:** _____ **Date:** _____

Other: _____

Do you currently wear glasses? ❑ Yes ❑ No **Contact lenses?** ❑ Yes ❑ No ❑ Neither

FAMILY OCULAR HISTORY (i.e. Glaucoma, Macular Degeneration, Diabetic Retinopathy)

RELATIVE	**AGE**	**EYE DISEASE**
Father	_____	_____
Mother	_____	_____

REVIEW OF SYSTEMS

Are you currently experiencing problems with any of the following?

SYSTEM			EXPLAIN/MEDICATIONS
• **Sudden weight gain or loss**	❑ Yes	❑ No	_____
• **Chronic fever or chronic fatigue**	❑ Yes	❑ No	_____
• **Heart** *(example: chest pain, angina, irregular heart beat)*	❑ Yes	❑ No	_____
• **Respiratory** *(example: coughing, wheezing, shortness of breath, asthma)*	❑ Yes	❑ No	_____
• **Ear/Nose/Throat** *(example: sore throat, sinus problems, earache, hearing loss)*	❑ Yes	❑ No	_____
• **Gastrointestinal** *(example: abdominal pain, heartburn, bowel problems, vomiting)*	❑ Yes	❑ No	_____
• **Urinary** *(example: pain when urinating, blood in urine)*	❑ Yes	❑ No	_____
• **Hematologic/Lymphatic** *(example: blood disorders, bruising, cuts heal slowly, enlarged glands)*	❑ Yes	❑ No	_____
• **Endocrine** *(example: thyroid problems)*	❑ Yes	❑ No	_____
• **Integumentary** *(example: rashes, dry skin)*	❑ Yes	❑ No	_____
• **Musculoskeletal** *(example: joint pain, stiffness or swelling, muscle pain)*	❑ Yes	❑ No	_____
• **Neurological** *(example: numbness, headache, seizures, paralysis)*	❑ Yes	❑ No	_____
• **Psychiatric** *(example: depression, anxiety, insomnia, confusion)*	❑ Yes	❑ No	_____
• **Allergic/Immunologic** *(example: reaction to food or drugs, allergies, hay fever)*	❑ Yes	❑ No	_____

REVIEWED BY PATIENT AND CHANGES AS INDICATED: **PHYSICIANS SIGNATURE**

Patient's Signature: _____ _____ **Date:** ____/_____/_____

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Patient's Signature: _____ _____ **Date:** ____/_____/_____

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