OCALA EYE, P.A.

001

PATIENT INFORMATION RECORD

CHART # _____ DR #_____ DATE: _____

PATIENT'S NAME (PLEASE PRINT)	SS #	BIRTH DATE	AGE	SEX M F
MAILING ADDRESS PERMANENT TEMPORARY	CITY AND STATE	ZIP CODE	HOME PHONE #	
EMAIL ADDRESS		CURRENT HEARING AID USE? Y / N		
PATIENT'S OR PARENT'S EMPLOYER	OCCUPATION	HOW LONG?	BUSINESS PHONE	
EMPLOYER'S STREET ADDRESS	CITY AND STATE		ZIP CODE	

MARITAL STATUS					SPOUSE OR PARENT'S NAME	SS #	BIRTH DATE
S	M	W	D	SEP			

The Federal Government requires us to ask the following as part of the American Recovery and Reinvestment Act.			
RACE (Please circle one):			
American Indian or Alaskan Native Alone	Asian	Black or African American	Native Hawaiian or other Pacific Islander
White	Other	Unknown or Decline to provide	
Ethnicity (Please circle one):			
Hispanic or Latino	Non-Hispanic or Non-Latino	Unknown or Decline to provide	
Language Preference (Please circle one):			
English	Spanish	Other:	

NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU		PHONE #	
REFERRING PHYSICIAN		PHONE #	HOW DID YOU HEAR ABOUT US?
PERSON RESPONSIBLE FOR PAYMENT	STREET ADDRESS, CITY, STATE	ZIP CODE	HOME PHONE #

MEDICAL INSURANCE INFORMATION

PRIMARY INSURANCE	ID/POLICY #	GROUP #
SUBSCRIBER'S NAME	SS #	BIRTH DATE
INSURANCE ADDRESS:		
SECONDARY / SUPPLEMENT INSURANCE	ID/POLICY #	GROUP #
SUBSCRIBER'S NAME	SS #	BIRTH DATE

I hereby authorize all licensed professionals employed by Ocala Eye to perform such professional diagnostic, laboratory, medical, and surgical procedures as are necessary in their judgement and to render such care and services as are customary and necessary.

Signature_____ Date_____

Name: _____

Email address: _____

REFRACTIVE SURGERY EVALUATION QUESTIONNAIRE

1. How did you hear about Ocala Eye? _____

2. Do you currently or have you taken any of these in the past 6 months:

[ ] Amiodarone	[ ] Imitrex	[ ] Treximet
[ ] Cordorazone	[ ] Acutane	
[ ] Axert	[ ] Frova	
[ ] Amerge	[ ] Zomig	
[ ] Relpax	[ ] Sansert	

3. Do you have a pacemaker? [ ] Yes [ ] No

4. (If patient is female) Are you or have you been pregnant/nursing in the last six months? [ ] Yes [ ] No
   Are you planning a pregnancy in the near future? [ ] Yes [ ] No

5. How long have you been wearing?

Glasses: _____

Contact Lenses:
Gas Permeable (hard) _____
Soft/Disposable _____

6. What type of work do you do? _____

7. What type of hobbies do you have? _____

8. How do your glasses/contacts affect your participation in work/leisure activities?

_____

9. What prompted you to consider having refractive surgery?

_____

10. What are your expectations from the surgery?

_____

RN Initials _____