

Date: _____

Name: _____ DOB: _____ Age: _____

Address: _____ City: _____

State: _____ Zip Code: _____ SSN: _____

Phone: _____ Cell: _____

Race/Ethnicity: _____ Marital Status: Single Married Divorced Widowed

Place of Employment: _____ Position _____

Vision Insurance Company: _____ Policy Number: _____

Policy Holder Name: _____ DOB: _____

Primary Insurance Company: _____ Policy Number: _____

Policy Holder Name: _____ DOB: _____

SSN: _____ Address: _____

Secondary Insurance Company: _____ Policy Number: _____

Policy Holder Name: _____ DOB: _____

SSN: _____ Address: _____

Primary Care Doctor: _____ Phone: _____

Please list any prior eye diseases and/or surgeries: _____

Are you having any problems with your eyes? _____

Do you or any of your family any history of the following eye diseases:

Macular Degeneration Yes _____ No _____

Glaucoma Yes _____ No _____

Other: _____

Please list any medical conditions and any surgical history: _____

Allergies: _____ **Are you allergic to fluorescein?** Yes _____ No: _____

Please list any medications you are currently taking: _____

Do you have problems with any of the following: If yes, please explain where applicable

Fever Yes _____ No _____ Weight Loss Yes _____ No _____

Heart Yes _____ No _____ Ear/Nose/Throat Yes _____ No _____

Endocrine Yes _____ No _____ Respiratory Yes _____ No _____

GI Yes _____ No _____ Muscular Yes _____ No _____

Skeletal Yes _____ No _____ Skin Yes _____ No _____

HIV Yes _____ No _____ TB Yes _____ No _____

Do you smoke? Yes _____ No _____ If so, packs per day: _____ Years Smoking: _____

Do you drink? Yes _____ No _____ Socially _____ Drinks per day: _____

For Insurance: I authorize the release of any medical or pertinent information necessary to process my claim. I authorize payment of medical benefits to Marie R. Levine OD. The Levine Eye Center's notice of privacy practices are available for your review. I understand that I am responsible for any charges not covered by my insurance plan

Signature: _____ Date: _____

(Parent if Patient is a Minor)