Patient Name:_____ Primary Care Physician:_____ Account:_____

Yes	No	SPECIAL CONSIDERATIONS		
		Communication problems (Hearing, Vision)	Medication Allergies:	
		Physical Limitations	Food/Other Allergies:	
		Pneumonia Vaccine – (If you are 65 years old or older)		

PREVIOUS HOSPITALIZATION OR OPERATIONS (Indicate Approximate Year)	**CURRENT MEDICATIONS** (Include prescriptions, eye drops, and over the counter medications and dosages)

HAVE YOU HAD (Please circle if listed)	Y	N		Y	N
Diabetes *Average Blood sugar:* *Last A1c:*			Any illness, cold, cough or fever within the last week:		
Hypoglycemia (low blood sugar)			Recently had exposure to any communicable diseases?		
Thyroid Problems			Is there a possibility you are pregnant? Last Menstrual Period:		
Heart Problems (Rheumatic Fever. Murmur, Chest Pain, Heart Attack, Irregular Heartbeat, EKG changes, Angina, Ankle Swelling, Valve Replacement, Pacemaker) ,Other:_____			Do you have a history or smoking? Packs per day: Date Quit:		
Blood Clots, Transfusion Problems			Do you drink alcoholic beverages: How often? How much?		
Bleeding Tendency (Hemophilia)			Do you have a history of, or are you taking any recreational drugs?		
Stroke (Weakness or Numbness on one side, Difficulty speaking, Loss of vision)			Do you have any of the following: Braces False Teeth Loose Teeth Bridges Capped Teeth Chipped Teeth		
High Blood Pressure			Arthritis		
Muscle Disorder (MD, Myasthenia Gravis)?			Do you wear contact lenses?		
Sleep Apnea			Are there any pain medications you cannot take? (Please list below)		
Tuberculosis/TB			Do you need a release from work or school?		
Lung Problems (Asthma, Chronic Cough, Pneumonia, Wheezing, Shortness of breath, Emphysema, Abnormal Chest X-ray)			Back or Neck or Broken Bones in Spine (Strain, Disc Problems, Numbness, or Tingling of Hands)		
Liver Problems (Jaundice, Hepatitis)			Stomach Problems (Ulcer, Hiatal Hernia, Reflux, Heartburn)		
Kidney, Bladder, or Prostate Problems (infections)			Bowel Problems (Irritable Bowel, Diverticulosis)		
Difficulty Opening Mouth (TMJ)			Are you receiving treatment for Glaucoma?		
Restrictions in movement?			Do you drive? Y N Do you live alone? Y N		
Cancer? Specify:			What are your past time/hobbies?		
Mental health issues/phobias			IF THE PATIENT IS A CHILD		
Skin disorders (Eczema)			Was the child premature?		
Other Medical Problems/Parkinson's disease			Any immunization problems or delays?		
Severe Headaches			Any birth defects or developmental problems?		
Seizures (Epilepsy, Convulsions, Blackouts)			Any history of breath holding, breathing problems, or croup?		

Have you ever had any of the following? If yes, approximately when?

	YES	NO	EYE	WHEN		YES	NO	EYE	WHEN
Eye injury	___	___	R L	_____	Eye infection	___	___	R L	_____
Lazy eye	___	___	R L	_____	Retinal detachment	___	___	R L	_____
Iritis	___	___	R L	_____	Blindness	___	___	R L	_____
Cataracts	___	___	R L	_____	Macular degeneration	___	___	R L	_____
Crossed eyes	___	___	R L	_____	Other_____			R L	_____
Glaucoma	___	___	R L	_____	Eye Surgery	___	___	R L	_____
					*Specify:*_____				

Please indicate if any of your family/blood relatives have any of the following medical conditions and the relation:

□ Other eye disorders: _____Relationship:_____
High blood pressure: _____ □ Diabetes: _____ □ Heart disease: _____
Cancer: _____ □ Macular degeneration: _____ □ Glaucoma:_____

Has a blood relative ever had a bad reaction to anesthesia? YES or NO

Patient/Legal Guardian Name: _____ Patient/Legal Guardian D.O.B. _____

Patient /Legal Guardian Signature:_____ Date: _____

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Account:_____

Patient Name:		D.O.B	Sex ▢ Male ▢ Female
Mailing Address:	City	State	Zip Code
Home Phone ( )	Daytime Phone ( )	Cell Phone ( )	Email
SS#	Occupation	Employer	Spouse's Name

Ethnicity ▢ Caucasian ▢ Hispanic ▢ Black/African American ▢ Asian ▢ Indian ▢ Pacific Islander ▢ Other:_____

Responsible party other than patient	Emergency contact *not living with you* (Name and Phone)

Primary Insurance	* Policy Holder Name	* Policy ID
Relationship to Patient	* Policy Holder's DOB	* Group Number
Secondary Insurance	* Policy Holder Name	* Policy ID
Relationship to Patient	* Policy Holder's DOB	* Group Number
Vision Insurance	* Policy Holder Name	* Policy ID
Relationship to Patient	* Policy Holder's DOB	* Group Number

What is the reason for today's visit? _____

Referring Doctor_____When was your last complete medical eye exam?_____

Are you a hospice patient? Yes No Initials_____

Do you have a preventative insurance benefit? Yes No
If yes, would you like to use it today? Yes No Initials_____

Payment for all medical services is the responsibility of the patient or legal guardian and is expected at the time of service.

PLEASE SHOW ALL INSURANCE CARDS TO THE FRONT DESK TO INSURE PROPER BILLING

I/We agree to pay all attorney fees, court costs, filing fees, including charges or commissions up to 50% that may be assessed to us by any collection agency retained to pursue this matter. I/We further agree to pay interest at the rate of one-and-a-half percent per month (18% per year) before and after judgment. I/We understand there is a $15.00 service charge for all returned checks.
I/We herby authorize the release of medical information concerning my illness and treatment by the doctors for the Zion Eye Institute/Jason Ahee MD PC to my insurance company, and the Health Care Financing Administration or its agents. I authorize payment of medical benefits to provider or facility.

_____ _____

Today's Date Signature of patient or legal guardian