Eye Care Specialists Of Florida

Caring for you, not just your eyes

First Name: _____ Last Name: _____ Date of Birth: _____ Gender: _____

Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip Code: _____

SSN: _____-_____-_____ Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____

Employer: _____ Occupation: _____ Work Phone: _____-_____-_____

E-Mail: _____ Pharmacy Name/Phone Number: _____

Referred By: _____ Primary Care Physician: _____

Insurance Carrier: _____ Member ID: _____ Group Number: _____

Primary Member of Insurance Name/DOB: _____ Relationship: _____

Do you drink? YES/NO Do you smoke? YES/NO Pregnant? YES/NO Primary Language: _____

Person authorized to receive medical information/Contact in case of an emergency:

Name: _____ Relationship: _____ Phone: _____

Current Medications: _____ Medication Allergies: _____

MEDICAL HISTORY

Do you currently have any of the following problems?	**Y**	**N**	**If yes, please explain:**
Ocular History (e.g. Glaucoma, Macular Degeneration)			
Ear, Nose, Throat (e.g. Sinus, hearing loss)			
Cardiovascular (e.g. Heart Disease, Hypertension)			
Respiratory (e.g. Asthma)			
Gastrointestinal/Digestive/Urinary			
Skin			
Muscles, Bones, Joints			
Endocrine (e.g. Diabetes, Thyroid Disease)			
Neurological/Psychiatric (e.g. Headaches, Depression)			
Cancer			
Major Surgeries			

Family History	**Y**	**N**	**Relationship to patient:**
Medical History			
Ocular HIstory			

Patient/Guardian Signature: _____ Relationship: _____ Date: _____

Doctor Signature: _____ Date: _____