Kristin Liffick Jacob, O.D.

PATIENT INFORMATION

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| Thank you for choosing our office for your eye care needs. We strive to provide the best care possible and appreciate the confidence you have placed in us. Please help us serve you better by completing these forms.Mr. Mrs. Ms. Dr. **Last Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**First Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Nickname:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** **of** **Birth**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age:**\_\_\_\_\_ **SSN Last 4**:\_\_\_\_\_\_\_\_\_**Marital Status**: [ ] Single [ ] Married [ ] Civil Union [ ] Other **Race:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**City:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State:**\_\_\_\_\_\_\_ **Zip:**\_\_\_\_\_\_\_\_\_\_**Home Phone:** (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell:** (\_\_\_\_ )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work:** (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For a Minor, Parent/Legal Guardian’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**How did you hear about our office?** [ ] Family/Friend [ ] Location [ ] Insurance [ ] Internet [ ] Professional ReferralWhom may we thank for referring you to us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Vision Insurance:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Primary Insured (If other than patient):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security # or ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Medical Insurance:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Your Reason for visiting our office today? (Check all that apply)

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| [ ] General/Routine Check up | [ ] Broken/lost contacts | [ ] Eyes itch/painful/uncomfortable | [ ] Filmy Vision |
| [ ] Desire contact lenses | [ ] Broken/lost glasses | [ ] Eyes red/swollen/tired | [ ] Flashes of light |
| [ ] Blurred near vision | [ ] Eyes crossed/wander | [ ] Eye strain | [ ] Floaters/spots in vision |
| [ ] Headaches/migraines | [ ] Eye discharge/mucus/water | [ ] Double vision | [ ] Light sensitivity |
| [ ] Night Blindness | [ ] Other, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Date of last eye exam:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age of present glasses:\_\_\_\_\_\_\_\_\_\_\_ Age of present contacts:\_\_\_\_\_\_\_\_\_Do you currently wear contacts? [ ] YES [ ] NO Type? [ ] Soft [ ] Gas Perm [ ] HardDo you need a contact lens prescription? [ ] YES [ ] NO *Contact lens fitting is an additional cost that your insurance may or may not provide. The fit can cost $50-$100. If you have any questions please let us know.*Do you work on a computer? [ ] YES [ ] NO Hours per day:\_\_\_\_\_\_\_\_Do you have special visual needs? [ ] YES [ ] NO Please list type of specialty activity:\_\_\_\_\_\_\_\_\_\_\_\_Please list any previous surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

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|  2. Have you had or are you being treated for any of the following conditions? (Check all that apply)

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| Recent weight loss or fever | [ ] No [ ] Yes | Details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Ear, nose, mouth, or throat disease | [ ] No [ ] Yes | Details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Neurologic disease | [ ] No [ ] Yes | Details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Psychiatric condition | [ ] No [ ] Yes | Details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| High blood pressure, heart or vascular disease | [ ] No [ ] Yes | Details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Lung or respiratory disease | [ ] No [ ] Yes | Details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Stomach or gastrointestinal disease | [ ] No [ ] Yes | Details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Urinary or kidney disease | [ ] No [ ] Yes | Details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Rosacea or skin disease | [ ] No [ ] Yes | Details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Thyroid or endocrine disease | [ ] No [ ] Yes | Details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Environmental allergies | [ ] No [ ] Yes | Details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Blood or lymph disease | [ ] No [ ] Yes | Details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

 3. Are you currently taking any prescription medication? [ ] No [ ] Yes Please List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_4. Are you allergic to any medication? [ ] No [ ] Yes Please List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_5. Do you have seasonal allergies? [ ] No [ ] Yes Please List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_6. Have you had any eye surgery? [ ] No [ ] Yes Please List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_7. Have you had any eye disease? [ ] No [ ] Yes Please List:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do any of your blood relatives have any of the following medical or ocular conditions? (Check all that apply)  If adopted and no medical history is known please check here [ ]

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| [ ] Hypertension | [ ] Diabetes | [ ] Cancer | [ ] Thyroid disease |
| [ ] Glaucoma  | [ ] Cataracts  | [ ] Lazy Eye | [ ] very poor eye sight |
| [ ] Macular degeneration | [ ] Eye disease | [ ] Heart disease |  |

 Do you drink alcohol? [ ] No [ ] Yes If yes [ ] Occasionally [ ] Daily How much:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you smoke? [ ] Never smoked [ ] Former smoker [ ] Current smoker How much:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| aName of PCP Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clinic Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_I authorize the release of information from my medical records if requested by Dr. Kristin Liffick Jacob in relationship to my health care.     **Initial** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |