NEW PATIENT INFORMATION

Name ____ Date ____________________
First Middle Last

Address _____________________________ City____________________ Zip ___________

Birth Date _________________ Sex ❑ Male ❑ Female Spouses's Name___________________________

Employer _________________ Work Phone (____) __________ Home Phone (____) __________
or parents work if under 18

Referred By _____________________________ Social Security #________________________

HEALTH INSURANCE

Do you have Medicare? ❑ Yes ❑ No Do you have Medicaid? ❑ Yes ❑ No

Primary Insurance ______________________________ GP# ____________________ Policy # ______________________

Supplemental Insurance __________________________ GP# ____________________ Policy # ______________________

There is no way for us to know positively whether we are a provider on your insurance plan.
Please call your carrier to verify your coverage with Dr. Bryant, Allison, or Dolan prior to your visit.

How will you be paying today?: ❑ Check ❑ Cash ❑ Credit Card

PAST MEDICAL & FAMILY HISTORY

How would you rate your general health: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Please list all medical conditions you are being treated for and when it was first diagnosed	List all medicines you are taking, even over the counter medicines:

Please list all drug allergies (even OTC-over the counter-medications)

Please list all operations you have had:

Who is your personal family physician:

Check Conditions That Are Present In Other Family Members:

❑ Crossed Eyes	❑ Glaucoma	❑ Arthritis	❑ Tuberculosis
❑ Retinal detachment	❑ Diabetes	❑ Lupus	❑?Lazy Eye
❑ Macular degeneration	❑ Cancer	❑ Heart Disease	❑ Other Inherited Conditions ______________________
❑ Blindness	❑ Blindness	❑ High Blood Pressure	❑ Other Eye Disease ___________________________

SOCIAL HISTORY

What has been your life occupation:

Do you live alone? ❑ Yes ❑ No	Are you able to drive? ❑ Yes ❑ No
Do you smoke? ❑ Yes ❑ No	Do you drink alcohol? ❑ Yes ❑ No

Reviewed by Dr. ___________________________________