JAY S. FOLKMAN, O.D., P.C. **Date: _____**

How did you find out about us? □ Insurance □ Internet □ Patient Referral_____

PATIENT INFORMATION

First Name: _____MI_____ Last Name:_____

Nickname: _____ Sex: □ Male □ Female

Date of Birth: _____ /_____ /_____ Age:_____ SSN: _____-_____-_____

Ethnicity: □ Hispanic/Latino □Non-Hispanic/Latino □Native Hawaiian/Islander

Race: □American Indian/Alaska Native □Asian □African American □Native Hawaiian/Islander □Hispanic □White

Marital Status: □ Divorced □ Legally Separated □ Married □ Single □ Widowed

Are you interested in learning more about Lasik surgery: □Y □N

CONTACT INFORMATION

Phone Numbers: Home:_____ Work: _____ Cell:_____

Mailing Address:_____

City:_____State:_____Zip:_____

Email:_____

Primary Care Physician: _____ PCP Phone:_____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone #: _____

Please list **ALL** Insurance plans you are covered under _____

Pharmacy Name: _____ Pharmacy Location: _____

For your privacy, please indicate the manner in which we may contact you:

□ Mail □ Home Phone □ Work Phone □ E-Mail □Cell Phone (Okay to text? □Y □N)

RESPONSIBLE PARTY & INSURANCE INFO. (IF DIFFERENT FROM ABOVE OR PATIENT IS A MINOR)

First Name: _____ Last Name:_____

SSN:_____-_____-_____ DOB: _____ /_____ /_____

Phone Numbers: Home:_____ Work: _____ Cell:_____

Address:_____City:_____State:_____Zip:_____

ACKNOWLEDGEMENT OF RECEIPT OF HIPPA Form (Privacy Policy)

I acknowledge that I have access to a copy of the Privacy Practice, Jay S. Folkman, O.D.

Signature: _____ Date: _____

Please ensure form is completely filled out to the best of your knowledge.

Please indicate if you have medical conditions involving the following body systems and give a brief description.

	Yes	No		
1	☐	☐	Ears/Nose/Throat/Mouth Disease	_____
2	☐	☐	Heart Conditions	_____
3	☐	☐	High Blood Pressure	_____
4	☐	☐	Blood Disorders	_____
5	☐	☐	High Cholesterol	_____
6	☐	☐	Urinary or Kidney Disease	_____
7	☐	☐	Muscle or Joint Conditions	_____
8	☐	☐	Skin Conditions	_____
9	☐	☐	Stroke/Neurological Disease	_____
10	☐	☐	Mental Health Conditions	_____
11	☐	☐	Thyroid Imbalance/Disease	_____
12	☐	☐	Seasonal Allergies	_____
13	☐	☐	Immune system conditions	_____
14	☐	☐	Asthma or Lung condition	_____
15	☐	☐	Stomach/Intestinal Conditions	_____
16	☐	☐	Diabetes	_____
			Last date and A1c, if known	_____
17	☐	☐	Other	_____

Indicate if you or any of your parents, brothers, or sisters has had the following conditions and briefly describe.

	Yes	No		
18	☐	☐	Glaucoma	_____
19	☐	☐	Macular Degeneration	_____
20	☐	☐	Eye Surgery	_____
21	☐	☐	Other Eye Disease	_____

Do you smoke currently smoke? ☐Yes ☐ No Packs/Day: _____ Years smoked? _____
Method of Tobacco intake: ☐ Smoking ☐ Chewing If former smoker, year quit smoking? _____

Do you use alcohol? ☐ Yes ☐No If so, frequency: _____

Medication	Dose/Frequency	Purpose

Are you allergic to any medication? ☐ No ☐ Yes (please list): _____