Howard A Ossen, O.D.

6113 Indian River Rd
Virginia Beach, VA 23464
Phone: (757) 420-2053
Fax: (757) 424-9503

Patient Information

PLEASE PRINT

(Last) (First) (M.I.)

Name: _____

Prefer name: _____

Address: _____ Apt #_____

_____

City State Zip

DOB: ___/___/___ AGE: _____ Sex: M F

SSN#: ____-____-_____

Preferences: Home / Work /Cell

Home: _____ Work: _____

Cell: _____

Email: _____

Marital Status: Single Married Divorced Widowed

WE ARE REQUIRED BY THE GOVERNMENT TO ASK THE FOLLOWING QUESTIONS:

Race:
___ American Indian or Alaska Native
___ Asian
___ Black or African American
___ Hispanic or Latino
___ Native Hawaiian or Other Pacific Islander
___ White

Ethnicity:
___ Hispanic or Latino
___ Not Hispanic or Latino

Preferred Language: _____

Employer: _____

Occupation: _____

IN CASE OF EMERGENCY

Name: _____

Relationship: _____

Contact #: _____

Responsible Party Information

Name: _____

Relationship: _____

Address: _____

_____

City State Zip

Phone: (___) _____-_____ H / W / C

INSURANCE

Primary Insurance: _____

ID#: _____ Group#: _____

Subscriber Name: _____

Subscriber DOB: ___/___/___SSN#: ____-___-_____

Secondary Insurance: _____

ID#: _____ Group#: _____

Subscriber Name: _____

Subscriber DOB: ___/___/___SSN#: ____-___-_____

Vision Insurance: _____

ID#: _____ Group#: _____

Subscriber Name: _____

Subscriber DOB: ___/___/___SSN#: ____-___-_____

How did you hear about our office? Circle one

Family Member	Friend	Doctor Referral
Office Website	Newspaper	Insurance Carrier
Location	Internet Search	Yellow Pages

MEDICAL HISTORY INFORMATION

First Name:_____ Last Name:_____ DOB:_____

Reason for visit:_____

FAMILY HISTORY: Please check off and indicate which family member might have the following. (Mother, Father, Siblings, Grandparents)

Blindness: _____
Cataracts: _____
Glaucoma: _____
Macular Degeneration: _____
Retinal Detachment: _____
Corneal Degeneration/Dystrophy: _____
Lazy Eye: _____
Diabetes: _____
Heart Disease: _____
Family History Unknown/Adopted: _____

Review of Systems: Please check off any symptoms **you** are currently having. If none apply to you, please check "NONE".

Constitutional
__Developmental disabilities
__Fatigue
__Cancer
__None

Genitourinary
__Pregnant
__Nursing
__STD
__Kidney Disease
__Prostate Cancer
__None

Allergic/Immunologic
__Environmental Allergy
__Rheumatoid Arthritis
__Lupus
__Sjogren's Syndrome
__None

Neurological
__Migraines
__Tumor
__Epilepsy
__Cerebral palsy
__Multiple Sclerosis
__Stroke
__None

Psychiatric
__Depression
__Attention Deficit
__Anxiety
__Bipolar Disorder
__None

Integumentary/Skin
__Eczema
__Rosacea
__Psoriasis
__Herpes Zoster/Shingles
__Herpes Simplex/Cold Sores
__None

ENT(Ear,Nose,Throat)
__Hearing Loss
__Laryngitis
__Dry Mouth
__Sinusitis
__None

Endocrine
__Diabetes
Type 1 / 2 FBS____ A1C___
__Thyroid Disease
__Hormonal Dysfunction
__None

Musculoskeletal
__Fibromyalgia
__Arthritis
__Gout
__Muscular Dystrophy
__Osteoarthritis
__None

Cardiovascular
__Heart Disease
__Hypertension
__Vascular Disease
__None

Respiratory
__Asthma
__Emphysema
__Bronchitis
__Sleep Apnea
__None

Gastrointestinal
__Crohn's Disease
__Colitis
__Acid Reflux
__Celiac Disease
__Ulcer
__None

Blood/Lymphatic
__Anemia
__Ulcer
__Hypercholesteremia
__None

Medication: _____ _____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____ _____ _____

Drug Allergies: _____ _____ _____ _____ _____ _____ _____

Social History:

Do you use tobacco products? Y/N If yes, type/amount/how long: _____
Do you use alcohol? Y/N If yes, type/amount/how long: _____
Do you use illegal drugs? Y/N If yes, type/amount/how long: _____

Do you wear glasses? Y/N Do you want an Eyeglasses prescription today? Y/N
Do you wear contacts? Y/N Are you interest in Contacts? Y/N

Who is your Primary Care Doctor? _____ Phone#: _____

Signature: _____ Date:____/_____/_____