HOFFNER
EYE CARE

Welcome To Our Office

Date: _____

Patient's Legal Name: _____ Nickname: _____ Mr.___ Mrs.___ Miss___ Ms.___

Spouse or Parent Name: _____ Mother's Maiden Name _____ Marital Status: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone (Home): _____ (Cell): _____ (Work): _____

E-mail Address: _____ Occupation: _____

Ethnicity: Asian _____ African American _____ Caucasion _____ Hispanic _____ Other _____

Birth Date: _____ Birth State: _____ Age: ____ Sex: M / F Preferred Language: _____

Family Physician Name: _____ Phone Number: _____

Do You Currently Wear Glasses? Y / N Contact Lenses? Y / N

Date of Last Eye Exam: _____ Dr.'s Name: _____

In Case Of Emergency Please Contact: Name: _____ Phone: _____

If this is your first visit, how did you hear of us? (Please Circle One)

Family Friends Doctor Advertising/Yellow Pages Passing by Insurance Other: _____

If referred, whom may we thank for the referral? _____

Vision Insurance: _____ D.O.B. of Primary: _____

Medical Insurance: _____ S.S. # of Primary: _____

PLEASE PRESENT YOUR INSURANCE CARD FOR US TO COPY FOR YOUR FILE.
PLEASE READ AND SIGN THE FOLLOWING:

Filing insurance claims is a service provided as a courtesy to our patients and in no way relieves patients of responsibility for payment. Patient is responsible for any balance not paid by the insurance company. Florida law requires insurance companies to pay within 30 days. It is the patients responsibility to resolve any conflict of benefits of payment.

HIPAA Privacy Disclosure: We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information. I authorize you to use or disclose my health information I am also acknowledging that I understand I may receive a paper copy with this authorization at my request.

Print Full Name: _____

Signature: _____ Date: _____

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PRELIMINARY HISTORY

EHR Information: The electronic health record, or EHR, is a means of storing important patient information and electronic medical records. Included in this information are patient demographics, progress notes, problems, medications, vital signs, past medical history, immunizations. EHR, technology represents a vast improvement over paper-based systems, and is changing the way healthcare is administered in medical practices.

GENERAL HEALTH

	SELF YES	DURATION	FAMILY YES - Relationship to You	
Glaucoma	☐	_____	☐	_____
Cataracts	☐	_____	☐	_____
Macular Degeneration	☐	_____	☐	_____
Blindness	☐	_____	☐	_____
Lazy Eye	☐	_____	☐	_____
Retinal Disease	☐	_____	☐	_____
Diabetes	☐	_____	☐	_____
Hypertension	☐	_____	☐	_____
Thyroid	☐	_____	☐	_____
High Cholesterol	☐	_____	☐	_____
HIV⊕	☐	_____	☐	_____
Other Conditions	☐	_____	☐	_____

CURRENT VISION PROBLEMS

	YES	DURATION
Distance Blurry	☐	_____
Near Vision Blurry	☐	_____
Problems Seeing At Night	☐	_____
Frequent Headaches	☐	_____
Double Vision	☐	_____
Objects Floating In Vision	☐	_____
Flashes Of Light	☐	_____
Eyes Itch/Burn/Water	☐	_____
Red/Dry Eyes	☐	_____
Eyestrain/Sore Eyes	☐	_____
Matter Or Discharge	☐	_____

List Any Eye Surgery Or Injury _____

If Pregnant: Due Date _____

Height: _____ Weight: _____

Smoking Status: Current / Former / None / Number of years: _____

Allergies: _____

List All Current Medications:

Names:	Dose:	Times per day:	Medical Condition:

(Office Use Only) Vitals _____