Jay S. Folkman, O.D., PC. Date: _____/_____/_____

How did you find out about us? ☐ Insurance ☐ Internet ☐ Patient Referral (list name) _____

Legal Name _____ Marital Status ☐ **M** ☐ **S** ☐ **D** ☐ **W**

Nick Name _____ Ethnicity ☐ Hispanic/Latino ☐ Non-Hispanic ☐ Native Hawaiian/Islander

DOB _____/_____/_____ SSN# _____ Race ☐ American Indian/Alaskan Native ☐ Asian ☐ African American

Address _____ ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White

_____ Employer _____

City_____ State_____ Zip_____ Occupation _____

Cell Phone _____ Primary Care Doctor _____

Home Phone _____ Phone _____

Daytime Phone _____ Pharmacy _____

Email _____ Last Eye Exam _____

For your privacy, please mark the manner in which we may contact you: ☐ Cell (OK to text?) ☐ Y ☐ N ☐ Home Phone ☐ Work Phone ☐ Email

Emergency Contact _____ Phone_____ Relationship_____

Please list **ALL** insurance plans under which you are covered _____

RESPONSIBLE PARTY & INSURANCE INFO (If different from above or the patient is a minor)

Name _____ Relationship _____

DOB _____/_____/_____ SSN# _____Phone # _____

Address _____ City_____ State_____ Zip_____

Past Medical History (mark yes or no)

Do you currently have, or previously had any of the following problems or conditions?

	Yes	No
Cardiovascular		
Arrhythmia	☐	☐
Elevated Cholesterol	☐	☐
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Stroke	☐	☐
Gastrointestinal		
Crohn's Disease/Colitis	☐	☐
Hepatitis A / B / C	☐	☐
IBS	☐	☐
Ulcer / Reflux / GERD	☐	☐
Endocrine		
Gout	☐	☐
Hypothyroidism	☐	☐
Hyperthyroidism	☐	☐
Hashimoto's Disease	☐	☐
Diabetic Suspect	☐	☐
Diabetes Type I	☐	☐
Diabetes Type II	☐	☐

Last A1c and date, if known

_____

	Yes	No
Genito-Urinary		
Bladder Urgency/Frequency	☐	☐
Herpes Simplex	☐	☐
Prostate Disorder	☐	☐
Prostate Cancer	☐	☐
Hematologic/Lymphatic		
Anemia	☐	☐
Breast Cancer	☐	☐
Bleeding Disorder	☐	☐
Immunologic		
AIDS	☐	☐
HIV Positive	☐	☐
Organ Transplant	☐	☐
Sjogren's Syndrome	☐	☐
Respiratory		
Asthma	☐	☐
COPD	☐	☐
Sleep Apnea	☐	☐
Emphysema	☐	☐
Chronic Bronchitis	☐	☐

	Yes	No
Musculoskeletal		
Chronic Pain	☐	☐
Joint/Muscle Pain	☐	☐
Osteo Arthritis	☐	☐
Rheumatoid Arthritis	☐	☐
Psychiatric		
Anxiety	☐	☐
Depression	☐	☐
Bipolar Disorder	☐	☐
Attention Disorder	☐	☐
PTSD	☐	☐
Neurological		
Migraines	☐	☐
Multiple Sclerosis	☐	☐
Parkinson's Disease	☐	☐
Seizure Disorder	☐	☐
Integumentary		
Skin Cancer	☐	☐
Lupus	☐	☐
Ears/Nose/Mouth/Throat		
Hearing Loss	☐	☐

Social History **Tobacco Use (**mark which one applies)

☐ Never a smoker ☐ Light tobacco smoker ☐ Every day smoker Packs a day:

☐ Former smoker Year quit?_____ ☐ Smokeless tobacco user Years?_____ _____

Alcohol ☐ No ☐ Yes If so, frequency _____

Please complete both sides of the form →

Miscellaneous

List ANY previous surgeries with dates and other medical issues:

_____

_____

_____

_____

_____

_____

_____

Ocular History

	Yes	No
Age-Related-Macular Degeneration	☐	☐
Amblyopia (Lazy eye)	☐	☐
Blindness	☐	☐
Cataracts	☐	☐
Cataract Surgery	☐	☐
Date:_____		
Glaucoma	☐	☐
Injury to the eye region	☐	☐
Keratoconus	☐	☐
Refractive Surgery (LASIK, PRK)	☐	☐
Retinopathy	☐	☐
Strabismus (Crossed eyes)	☐	☐
Dry Eye	☐	☐

Other:

_____

Medications

☐ No medications

List prescriptions, over the counter, eye drops, and dosages for each

_____

_____

_____

_____

_____

Medication Allergies

☐ No medication allergies

list any allergies you have as well as the reaction

_____

_____

_____

_____

_____

Family Health History (mark yes or no to each question)

If yes, list which family member, including mother, father, siblings, maternal/paternal aunts/uncles, maternal/paternal grandparents

	Yes	No			Yes	No	
Amblyopia	☐	☐	_____	**Cancer**	☐	☐	_____
Blindness	☐	☐	_____	**Diabetes Mellitus**	☐	☐	_____
Cataract	☐	☐	_____	**Heart Disease**	☐	☐	_____
Cataract surgery	☐	☐	_____	**High Blood Pressure**	☐	☐	_____
Glaucoma	☐	☐	_____	**Heart Attack**	☐	☐	_____
Macular Degeneration	☐	☐	_____	**Stroke**	☐	☐	_____
Strabismus	☐	☐	_____	**Other** _____			
Retinal disorder	☐	☐	_____				

Acknowledgment of Notice of Privacy Practices

The law requires that Jay S. Folkman, O.D., P.C. make every effort to inform you of your rights related to your personal health information. By signing below, I acknowledge that:

___ I was given the opportunity to read, have read or had explained to me Jay S. Folkman, O.D., P.C.'s Notice of Privacy Practice prior to any services offered.

___ The Notice of Privacy Practice could not be read due to the emergent nature of the care and will be acquired when possible.

I authorize Jay S. Folkman, O.D., P.C. to release my personal health information to the following individuals:

_____ _____ _____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY

Signature: _____ Date: _____

If you are signing as a personal representative of the patient, please indicate your relationship:

_____ _____

Representative Signature Relationship to Patient