PATIENT HISTORY QUESTIONAIRE DR RICHARD ZOBEL OD

****PLEASE TURN OFF CELLPHONES DURING YOUR OFFICE VISIT.**

It is the patient's responsibility to inform the office of any insurance before the examination.

PT. LAST NAME_____FIRST NAME_____MI_____

ADDRESS_____CITY_____STATE_____ZIP_____
E-MAIL ADDRESS_____
TELEPHONE HOME_____WK_____SOC SEC#_____BIRTHDATE_____
OCCUPATION_____EMPLOYER_____

PARENT OR GUARDIAN_____
NAME OF SPOUSE AND FAMILY MEMBERS_____

MEDICAL INSURANCE…Y….N…..NAME OF INSURANCE_____
VISION INSURANCE……Y…..N…..NAME OF INSURANCE_____
DATE OF LAST EYE EXAM_____LAST DR._____

MEDICAL INFORMATION

DO YOU HAVE PROBLEMS WITH ANY OF THESE SYSTEMS?

DIABETES…..Y…..N…..TYPE_____ DATE DIAGNOSED_____
EARS/NOSE/THROAT…….Y…..N…..
ALLERGIES…….. Y…..N ALLERGIES TO MEDICATIONS…..Y…..N…..WHICH ONES_____
CARDIOVASCULAR……...Y…..N…..
RESPIRATORY…… Y…..N….. NAME OF FAMILY DOCTOR_____
MUSCULOSKELETAL…….Y…..N….. Ph#_____
SKIN CONDITIONS……..Y…..N….. Address_____
PSYCHOLOGICAL……Y…..N….. _____
ENDOCRINE (GLANDS)…..Y…..N…..
BLOOD/LYMPH……Y…..N…..
HAVE YOU HAD ANY OPERATIONS?.....Y…..N….. TYPE_____
MEDICATIONS YOU TAKE NOW_____

FAMILY HISTORY

HIGH BLOOD PRESSURE……Y…..N…..RELATION_____
MACULAR DEGENERATION……..Y…..N…..RELATION_____
DIABETES…… Y…..N…..RELATION_____
RETINAL DETATCHMENT……..Y…..N…..RELATION_____
GLAUCOMA…… Y…..N…..RELATION_____
CATARACTS……...Y…..N…..RELATION_____
OTHER EYE CONDITIONS…… Y…..N…..RELATION_____WHAT KIND_____

PERSONAL EYE INFORMATION

HAVE YOU HAD ANY EYE OPERATIONS…..Y…..N…..TYPE_____.DATE_____
HAVE YOU HAD ANY EYE INJURIES……..Y…..N…..KIND_____DATE_____
DO YOU HAVE GLAUCOMA……..Y…..N….. CATARACTS…….Y…….N……..
DRY EYES……Y…..N….. BLURRED VISION……Y…..N…..
DO YOU WEAR GLASSES……Y…..N….. CONTACT LENSES…..Y…..N…..
WHO REFERRED YOU TO OUR OFFICE?
_____

I HEREBY GRANT PERMISSION FOR DR ZOBEL TO EXCHANGE INFORMATION WITH MY INSURANCE CONCERNING MY CASE HISTORY, RESULTS OF MY EXAMINATION DIAGNOSIS, TREARMENT, ETC…I HEREBY ASSIGN ALL MEDICAL BENEFITS TO WHICH I AM ENTITLED. I UNDERSTAND THAT I AM FINANCILLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. IT WILL BE THE PATIENTS RESPONSIBILITY TO PROVIDE OUR OFFICE WITH ANY REQUIRED REFERAALS. I AUTHORIZE THIS OFFICE TO RELEASE ANY INFORMATION NEEDED TO DETERMINE THESE BENFITS OR THE BENFITS FOR RELATED SERVICES. PATIENT WITHOUT INSURANCE ARE RESPONSIBLE FOR ALL CHARGES AT THE TIME OF VISIT.

PATIENT NAME_____ DATE_____