Chester Family
Eye Care

Patient Demographic Information:

First name: _____ MI: _____ Last name: _____

Gender: M/F/Other Social Security #: _____-_____-_____ Date of Birth: _____/ ____ / _____

Address: _____

City: _____ State_____ Zip code: _____

Primary Phone: (_____) _____-_____ (mobile/home/work)

Secondary Phone: (_____) _____-_____ (mobile/home/work)

Email Address: _____@ _____

Emergency contact name: _____ Relationship to you: _____

Emergency contact phone: (_____) _____-_____ (mobile/home/work)

Race:

___American Indian or Alaska native ___Native Hawaiian or pacific islander

___Asian ___White

___Black or African American ___Decline to answer

Ethnicity:

____Hispanic ____Not Hispanic or Latino ___Decline to answer

Preferred Language: _____

Insurance information:

Vision insurance: _____ID: _____

Primary medical: _____ ID: _____Group #: _____

Secondary medical: _____ ID: _____Group #_____

Subscriber name: _____ DOB: _____/ ____ / _____ Relation to you: _____

Subscriber employer: _____ Last 4 of subscriber social: _____

**PLEASE BE ADVISED THAT YOUR INSURANCE COVERAGE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. AS A COURTESY OUR OFFICE WILL ATTEMPT TO VERIFY ALL BENEFITS BEFORE SERVICES ARE RENDERED, ULTIMATELY HOWEVER, KNOWLEDGE OF BENEFITS AND COVERAGE IS PATIENT RESPONSIBILITY. **

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Patient Medical History and Review of Systems:

First name: _____Last name: _____ Date: ___/____/_____

Primary care physician: _____ Phone: (_____) _____-_____

Please check off if you currently have or are experiencing any of the following conditions (if not listed, write in other)

cardiovascular
- ____hypertension
- ____high cholesterol
- ____arrhythmia (e.g. a-fib)
- ____other:_____

gastrointestinal:
- ____abdominal pain
- ____nausea
- ____diarrhea
- ____other:_____

integumentary:
- ____acne
- ____skin cancer
- ____psoriasis
- ____other:_____

neurologic:
- ____weakness
- ____headache
- ____double vision
- ____other:_____

ear nose throat:
- ____hearing loss
- ____dry mouth
- ____ear pain
- ____other:_____

blood and lymph:
- ____hiv/aids
- ____cancer (what kind:_____)
- ____anemia
- ____other:_____

constitutional:
- ____fever
- ____weight loss
- ____chills/night sweats
- ____other:_____

musculoskeletal:
- ____muscle pain
- ____joint pain
- ____arthritis(non rheumatoid)
- ____other:_____

endocrine:
- ____diabetes (type 1/type 2)
- ____excess thirst/urination
- ____heat/cold intolerance
- ____other:_____

auto-immune:
- ____rheumatoid arthritis
- ____sjogrens
- ____lupus
- ____other:_____

respiratory:
- ____cough
- ____asthma
- ____sleep apnea
- ____other:_____

psychiatric:
- ____anxiety
- ____depression
- ____adhd
- ____other:_____

smoking status: current/former/non-smoker
height:_____ ft _____ in
weight (approx) _____ lbs

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List all medications taken and dosages:

_____
_____
_____
_____

List all allergies, including to medicine: (if none, write none)

_____
_____
_____
_____

Patient Ocular History: Please check off if you have a history of, or are experiencing any of the following conditions (if not listed, write in other, include eye surgeries)

____glaucoma	____blurred vision	____dry eye
____macular degeneration	____keratoconus	____allergic eye (itchy)
____cataracts	____amblyopia (lazy eye)	____iritis

other:_____
_____
_____
_____
_____

Digital Retinal Screening:

At Chester Family Eye Care, we pride ourselves in being able to offer some of the latest technology in ocular health screening. As part of our comprehensive eye examinations our doctors recommend every patient undergo a digital retinal screening. This screening utilizes an advanced camera system to acquire a digital image of the back of the eye (retina) in order to non-invasively assess up to 200 degrees of the retina, the optic nerve and macula. This screening helps our doctors more accurately diagnose diseases such as diabetic retinopathy, macular degeneration, glaucoma, and many other retina/optic nerve disorders. Insurances typically do not cover digital retinal screening, so there is an additional $39 copay for this service. This digital retinal screening however, does not replace a dilated eye examination. If our doctors determine a dilated eye examination is required, a follow up visit may be scheduled. All patients who are dilated are encouraged to bring a driver with them to the visit as your vision will be blurry for up to 4-6 hours.

** BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND VERIFIED ALL OF THE ABOVE, AND HAVE HAD ANY QUESTIONS ANSWERED **

Patient/Legal Guardian sig: _____ Date: ____ / ____ / _____