Oklahoma Eye Institute

Patient Data Sheet

Account #_____

First Name: _____ Middle Initial: _____ Last Name: _____

Address: City: _____ State: _____- Zip: _____

Date of Birth _____ Age : _____ Marital Status: _____ Sex: _____

SS #_____ Driver License # _____

Home Phone _____ Work Phone _____ Cell Phone _____

Other/Emergency Phone _____ E-mail: _____

Optometrist: _____ Referring Physician:_____ Primary Care Physician_____

How did you hear of OEI? (circle) Family or Friend Insurance Plan Optometrist TV Ad Other _____

Employer: _____

Emp Address: _____City/State/Zip: _____

Insurance Information

Primary Insurance_____ I.D. #: _____ Group#: _____

Secondary Insurance: _____ I.D. #: _____ Group#: _____

Primary Insured/ Responsible Party Information

(If different from patient information)

SS # _____ Name: _____ Relationship to patient _____

Address_____ City_____ State _____ Zip Code _____

Date of Birth: _____ Age : _____ Marital Status: M S D W Sex: M F

Home Phone _____ Work Phone (____)_____ Cell (_____)_____

Employer:_____

Visit Information

Reason for your visit? _____

If this visit is due to an accident, please provide accident date _____

Privacy Information

Friend/relative whom we may contact in an emergency and/or regarding your visit if necessary? (HIPPA compliance):

1) _____ Relationship: _____ Phone #: _____

2) _____ Relationship: _____ Phone #: _____

I certify that I have been provided the OEI Patient Information Privacy Notice:

_____ _____ _____

Patient Signature Date OEI Employee

Authorization of Care

I authorize Oklahoma Eye Institute to examine me and perform such tests and procedures as are reasonable and necessary in the diagnosis and treatment of my care. If I am not the patient, but instead signing on behalf of the patient, I further certify that I am legally authorized to sign on the patient's behalf.

Patients Signature_____Date_____

Representative's Signature_____Date_____

Relationship of Representative to Patient _____

Oklahoma Eye Institute

PATIENT NAME: _____
DATE:_____
DOB: _____

MEDICAL HISTORY (*CIRCLE ALL THAT APPLY)*

ANXIETY ARTHRITIS RHEUMATOID ARTHRITIS CANCER:TYPE_____ DIABETES:TYPE_____ AIC:_____ HISTORY OF HEAD TRAUMA HISTORY OF EYE TRAUMA HISTORY OF HEART ATTACK HIV HEART DISEASE HEPATITS:TYPE_____ HIGH BLOOD PRESSURE HIGH CHOLESTEROL LUNG PROBLEMS:TYPE _____ HISTORY OF HEART ATTACK	LUPUS MIGRAINES PSYCHIATRIC PROBLEMS PACEMAKER IMPLANT SLEEP APNEA SHINGLES STROKE THYROID PROBLEMS TUBERCULOSIS TAKEN FLOMAX? Y or N OTHER HEALTH HISTORY:_____ _____ _____ _____ _____ _____	**DO YOU HAVE OR HAD?** ***CATARACTS** ***GLAUCOMA** ***MACULAR DEGENERATION** ***RETINAL DETACHMENT** _____ **HAVE YOU TAKEN FLOMAX Y OR N?**	**ALL SURGERIES** **(***INCLUDING EYE)* _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _

CURRENT MEDICATIONS:

_____

_____

_____

FAMILY HISTORY:
CATARACTS YES NO WHOM:_____
GLAUCOMA YES NO WHOM:_____
DIABETES YES NO WHOM:_____
MACULAR DEGENERATION YES NO
WHOM:_____
RETINAL DETACHMENT YES NO
WHOM:_____

DRUG ALLERGIES:

_____
_____
_____
_____
_____

PHARMACY NAME:_____ **LOCATION:**_____

SOCIAL HISTORY:
ALCOHOL USE: YES NO
SMOKE: YES NO YEARS:_____
TOBACCO: YES NO YEARS:_____

HAVE YOU HAD A:
FLU SHOT THIS YEAR: YES NO

PNEUMONIA SHOT THIS YEAR: YES NO

DO YOU WEAR CONTACTS? YES NO

DAILY? YES NO

HOW LONG?_____

_____