PATIENT HISTORY FORM

MATHER VISION GROUP

1401 Union Street. Lafayette, IN 47904

Last Name______________________________ First Name____ MI____
Address_______________________________________City______________________________________Zip________
Telephone (H)__________________(C)_________________(W)______________Email_________________________
Date of Birth_______________Social Security Number______-____-______Employer___________________________
Insurance Name____________________________________Insurance Number_________________________________
Emergency Contact________________________________Emergency Contact Number________________________

Medical Information

How is your general health?____

Do you have any health problems with the following systems? (circle all that apply)

Gastrointestinal	Y / N	Nervous	Y / N	Mental Health	Y / N
Ears/Nose/Throat	Y / N	Genitourinary	Y / N	Endocrine (glands)	Y / N
Cardiovascular	Y / N	Musculoskeletal	Y / N	Blood/Lymph	Y / N
Respiratory	Y / N	Skin Disorders	Y / N	Immune System	Y / N

Please Explain____

Have you had any operations? Y / N Explain____

Do you currently use tobacco products? Y / N Alcohol Y / N

Please Answer All That Apply

Diabetes Y / N Type__________ Date of Diagnosis__________ Last Glucose Reading__________Controlled Y / N

Allergies Y / N To What? _________________________________Reactions______________________________

Do you suffer from red, itchy, or watery eyes? Swollen eye lids?____

Do you use over the counter eye drops (i.e. Visine, ect) to treat red or itchy eyes?____________________________

Do you take oral medication like Claritan, Allegra, or Zyrtec for your allergies?_______________________________

Medication Allergies?____

High Blood Pressure Y / N Last reading________________________________Controlled Y / N

Frequent Headaches Y / N Locations____

Current Medications____
____

Family Doctor_____________________________________Diabetic Doctor_______________________________

Family History

High Blood Pressure Y / N Relation_____________ Macular Degeneration Y / N Relation___________________

Diabetes Y / N Relation_____________ Retinal Detachment Y / N Relation___________________

Glaucoma Y / N Relation_____________ Cataracts Y / N Relation___________________

Other Eye Conditions____Relation___________________________

Personal Eye Health Information

Have you had any eye operations? Y / N Type__________________________Date(s)_________________________

Have you had an eye injury? Y / N Type___________________________Date(s)_________________________

Do you have glaucoma? Y / N Cataracts? Y / N Dry Eyes? Y / N Blurred Vision? Y / N

Other Eye Conditions____

Do you wear glasses? Y / N Contacts? Y / N Type?____

Do you have any special visual tasks or sports?____

Additional Information____

Whom may we thank for referring you?____

It is our goal to provide you with the utmost care and professionalism. With this in mind, we ask you to be prompt with your payments for services rendered and/or materials received. In addition, if no payment is received you may be charged collection and attorney fees - if necessary. Therefore, once your insurance has been processed you are responsible for the balance within 60 days. **If you are unable to keep your scheduled appointment, please give a 24 hour advanced notice to insure that you will not be charged a $50 missed appointment fee.**

By signing below, you also agree to our Notice of Privacy Practices, which are available upon request.

I also give permission to ______________________________________ to have access for my medical records.

Patient/Parent Signature____Date_______________________