PATIENT MEDICAL AND OCULAR HISTORY / MEDICATION SHEET (updated 01/24/2014)

GENDER: M____ F____ RACE_____

NAME:_____ SMOKING STATUS:___current ___former ___never

DRUG ALLERGIES:_____ TOBACCO USE: ___current ___former ___never

FAMILY DOCTOR NAME:_____ DR. PHONE #:_____

PHARMACY PREFERRED:_____ City Pharmacy is located in:_____

LIST MEDICATIONS (both prescription and non-prescription) include dosage and frequency

_____

_____

_____

_____

YOUR CURRENT MEDICAL and EYE CONDITIONS please CIRCLE all that apply:

Cataracts	Diabetes	Anemia	Kidney Disease	Other:_____
Glaucoma	Hypertension	Asthma	Bleeds Easily	_____
Macular Degeneration	Arthritis	Thyroid	Cholesterol	_____
Eye Disease	Heart Disease	Cancer	Sleep Apnea	_____

YOUR PAST MEDICAL AND EYE CONDITIONS (example: Cataract Surgery, Cancer, etc.)

_____

_____

_____

_____

YOUR FAMILY HISTORY Please CIRCLE if your PARENTS or SIBLINGS has or had any of the following conditions:

Cataracts	Diabetes	Anemia	Kidney Disease	Other:_____
Glaucoma	Hypertension	Asthma	Bleeds Easily	_____
Macular Degeneration	Arthritis	Thyroid	Cholesterol	_____
Eye Disease	Heart Disease	Cancer	Sleep Apnea	_____

I authorize Margaret J. Swinker, OD to treat me and assign payment of authorized Medicare benefits & any other medical, vision, and/or surgical benefits to include major medical benefits, to which I am entitled, to be made to Margaret J. Swinker, OD, on my behalf for any other services furnished to me. Be advised, that both medical and vision benefits may be billed at the time of service. I authorize any holder of medical information about me to release any information needed to determine these benefits payable for related services. I also authorize the release of medical information regarding history, evaluation, treatment, scheduling, progress reports, & prescriptions to specialists/physicians/facilities involved in optimal continuity of my care. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.
I also acknowledge that the office of Margaret J. Swinker, OD adheres to the "NOTICE OF PRIVACY PRACTICE" as mandated by HIPAA.

X_____ _____

PATIENT OR GUARDIAN SIGNATURE DATE
