



Marietta Eye Clinic  
895 Canton Rd Bldg 100  
Marietta, GA 30060  
(770) 427-8111

How did you hear about our clinic? \_\_\_\_\_

Referred By \_\_\_\_\_ Phone # \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone # \_\_\_\_\_

### PATIENT INFORMATION

Patient Name \_\_\_\_\_ SSN \_\_\_\_\_ Birthdate \_\_\_\_\_ Gender \_\_\_\_\_

Address \_\_\_\_\_ Apt# \_\_\_\_\_ City State Zip \_\_\_\_\_

Home Phone#( ) \_\_\_\_\_ Work Phone#( ) \_\_\_\_\_ Email \_\_\_\_\_

Marital Status \_\_\_\_\_ Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employers Address \_\_\_\_\_ City State Zip \_\_\_\_\_

#### If patient is a minor (Under 18 or full time student)

Guarantor \_\_\_\_\_ SSN \_\_\_\_\_ Birthdate \_\_\_\_\_ Gender \_\_\_\_\_

Guarantor Address \_\_\_\_\_ City State Zip \_\_\_\_\_

#### (If different from patient)

Emergency Contact \_\_\_\_\_ Phone# \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Spouse Name \_\_\_\_\_ SSN \_\_\_\_\_ Birthdate \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone# \_\_\_\_\_

### INSURANCE INFORMATION

Primary Insurance \_\_\_\_\_ Policy# \_\_\_\_\_ Group# \_\_\_\_\_

Address \_\_\_\_\_ City State Zip \_\_\_\_\_

Insured Name \_\_\_\_\_ SSN \_\_\_\_\_ Birthdate \_\_\_\_\_

Phone# \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Policy# \_\_\_\_\_ Group# \_\_\_\_\_

Address \_\_\_\_\_ City State Zip \_\_\_\_\_

Insured Name \_\_\_\_\_ SSN \_\_\_\_\_ Birthdate \_\_\_\_\_

Phone# \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Do you have a vision policy? Name \_\_\_\_\_ Insured \_\_\_\_\_ Policy# \_\_\_\_\_

Phone# \_\_\_\_\_

I certify that the above information is correct and hereby authorize the release of medical information to my insurance company and/or to my referring physician. I assign to the physician(s) all payments for services rendered to my dependents or me. A copy of this authorization may be used in place of original. Insurance will be filed if the physician(s) are covered under my plan. It is my responsibility to obtain a referral if required. I understand that I will be responsible for all non-covered service, co-payments and deductibles. I hereby voluntarily consent to treatment at his/her office and authorize such treatments, examinations, medications, anesthesia, surgical, operations and diagnostic procedure as ordered by attending physician. Payment is due at time of service. A \$25 fee will be charged for all returned checks.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Please hand sign after printing.  
You may not save this document to your computer, so you must print a copy if you would like one for your personal records.  
Please bring this form with you to your appointment.

**Marietta Eye Clinic**  
**Patient Health History Questionnaire**  
Please complete in full and return to the Receptionist

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_

Were you referred by a physician:  Yes  No If so who? \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone number \_\_\_\_\_

1. Do you have a history of:  diabetes  high blood pressure  arthritis  asthma  thyroid disease  
 cardiac problems  kidney disease  migraines  lung disease  liver disease  cancer  
 hay fever  neurological disease  
If yes, explain: \_\_\_\_\_

2. Do you have any other medical problems? If yes, please explain: \_\_\_\_\_

3. Have you ever been told you have any of the following?  glaucoma  cataract  retinal detachment  
If yes, please explain: \_\_\_\_\_

4. Any other eye problems? \_\_\_\_\_

5. Do you wear: glasses  contact lenses  Last prescription change \_\_\_\_\_

6. Have you ever had surgery, including eye surgery:  yes  no If yes, explain: \_\_\_\_\_

7. Have you ever been hospitalized:  yes  no If yes, explain: \_\_\_\_\_

8. List any medication that you take, including eye drops:


9. Do you have any allergies to food or drugs?  yes  no If yes, list: \_\_\_\_\_

10. Do you have any of the following problems?

	Yes	No	Explain
Chronic fever, unexpected weight loss/gain, fatigue	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear/nose/throat problems (hearing, sinus etc)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart problems (chest pain, irregular heart beat)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory problems (shortness of breath, wheezing)	<input type="checkbox"/>	<input type="checkbox"/>	_____
GI problems (heartburn, abdominal pain, diarrhea)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinary problems (pain, blood in urine, kidney stones)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin problems (rashes, excessive dryness)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal problems (aches, joint pain, swollen joints)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological problems (numbness, headaches, stroke)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric problems (depression, anxiety)	<input type="checkbox"/>	<input type="checkbox"/>	_____

11. Do any medical or eye diseases run in your family (diabetes, high blood pressure, cancer, glaucoma, macular degeneration)?  yes  no If yes, explain: \_\_\_\_\_

12. Do you smoke?  yes  no How much? \_\_\_\_\_  
Do you drink alcohol?  yes  no How much? \_\_\_\_\_  
Do you use any recreational drugs?  yes  no What type? \_\_\_\_\_ How much? \_\_\_\_\_

\_\_\_\_\_  
Patient's Signature Date

\_\_\_\_\_  
Physician's Signature Date

Revised 04/06/06

NOTE: You may not save this form to your computer! You MUST print when complete.  
Please bring this form to your appointment.