Please bring forms with you to your visit along with all insurance cards and list of medications (or complete below) include vitamins.

Medical Information : Many health conditions affect the eyes **NEW** **EST**

1. Do you have any of the following conditions: (Please circle "Y" if pertain to you)

Seasonal allergies	Y	Dry mouth (Head)	Y	Psychological Disease (Psy	Y
Vascular Disease (Ca)	Y	Headaches – frequent (Head)	Y	Asthma (Rep)	Y
High Cholesterol (Ca)	Y	Migraines (Head)	Y	COPD (Rep)	Y
High Blood Pressure (Ca)	Y	Hearing loss (Head)	Y	Emphysema (Rep)	Y
Stroke (Ca)	Y	Sinus problems (Head)	Y	Cancer type:_____	
Heart Trouble (Ca)	Y	Anemia (HE)	Y	Other: _____	
Heart surgery (Ca)	Y	Bleeding problems (IN)	Y	_____	
Fatigue (Co)	Y	Autoimmune Disease (IN)	Y		
Sleep Apnea (Co)	Y	Acne (IN)	Y	**Eye problems**	
Weight (Co) loss or gain		Rosacea (IN)	Y	Lazy eye RT or LT	Y
Diabetes – Type 1 (E)	Y	Psoriasis (IN)	Y	Color blindness	Y
Diabetes – Type 2 (E)	Y	Skin Cancer	Y	Blindness	Y
Diabetic Suspect (E)	Y	Osteoarthritis (Mus)	Y	Cataracts	Y
Thyroid – overactive (E)	Y	Rheumatoid Arthritis (Mus)	Y	Glaucoma	Y
Thyroid – underactive (E)	Y	Joint pain (Mus)	Y	Macular degeneration	Y
Acid Reflux (Ga)	Y	Multiple Sclerosis (Ne)	Y	Dry Eyes	Y
GI problems (Ga)	Y	Seizure (Ne)	Y	Flashes new or old	Y
Kidney problems (Ge)	Y	ADD or ADHD (Psy)	Y	Floaters new or old	Y
Prostate (Ge)	Y	Alzheimer's (Psy)	Y	Eye injury	Y
Pregnant (Ge)	Y	Anxiety (Psy)	Y	Eye Surgery	Y
Nursing (Ge)	Y	Depression (Psy)	Y	Other: _____	

2. Please list all current medications or provide complete list: _____

_____

_____

3. Primary Care Physician: _____

4. Do you drink alcohol? No Social Daily Other _____

5. Do you smoke? Yes # of years _____ No Former Smokeless tobacco Other

6. Family history

						Grandmother	**Grandfather**
Diabetes -	**None**	Father	Mother	Sister	Brother	*Maternal or Paternal*	*Maternal or Paternal*
High Blood Pressure	**None**	Father	Mother	Sister	Brother	*Maternal or Paternal*	*Maternal or Paternal*
Cataracts	**None**	Father	Mother	Sister	Brother	*Maternal or Paternal*	*Maternal or Paternal*
Glaucoma	**None**	Father	Mother	Sister	Brother	*Maternal or Paternal*	*Maternal or Paternal*
Macular degeneration	**None**	Father	Mother	Sister	Brother	*Maternal or Paternal*	*Maternal or Paternal*

IF NEW PATIENT, HOW DID YOU HEAR ABOUT US? (PLEASE CIRCLE ONE OF THE FOLLOWING) WEBSITE FAMILY
DRIVE BY YELLOW PAGES PENNYSAVER INSURANCE FRIEND DOCTOR OTHER □

PT PREFERRED NAME OR NICKNAME: _____ Name: _____

PREFERRED COMMUNICATION: Telephone Cell Email Text Address:_____

_____

DAYTIME # : _____ **CELL #** _____ Date of Birth:_____

E-MAIL ADDRESS for Patient Portal :_____

MARITAL STATUS: Married Single Divorced Separated Widowed **PREFERRED LANGUAGE:** English or Spanish

RACE\ETHNICITY: Caucasian\White Asian American Indian\Alaska Native Black\African American American Hispanic\Latino Hawaiian\Other Pacific Island

EMPLOYMENT: FT or PT **Place of Employment \ Occupation**: _____ Unemployed Retired Military Student: FT or PT

X INSURANCE SUBCRIBER INFO: NAME: _____RELATIONSHIP TO PT_____ D OF B_____

ADDRESS, IF DIFFERENT FROM PT:_____

SIGNATURE ON FILE\FINANCIAL RESPONSIBILTY

I authorize use of this form on **all** insurance submissions. I **authorize** release of information to **all insurance companies**.
I authorize the doctor to act as **my** agent in helping to obtain payment from the insurance companies.
I authorize payment **direct** to the doctor. **I permit** a **copy** of this authorization to be used in place of the original.
I understand that I am responsible for any bills incurred.
I understand that **I am responsible** for any items not covered by insurance or over insurance allowances, items may include **refraction, eyewear (frame and lens), contacts, retinal photography.**
I understand that **I am responsible** for 1 $^{1}/_{2}$ % interest monthly, Attorney's fees, and collection costs on any unpaid balances.
I understand that my account will be assessed a fee of $35 for any appointment missed\cancelled without 24 hour notice.
I understand for any checks returned for insuffient funds will be assessed a fee of $20.00

X Signature: _____Date:___ /___ /____ Relationship: Self Parent Other

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ACKNOWKEDGEMENT OF RECEIPT AND GENERAL CONSENT

I acknowledge that I viewed a copy of Michael J. Dolan, O.D,'s Notice of Privacy Practices.

I further consent to the release of my health information for purposes of treatment, payment, and health care operations and as authorized or required by law under the circumstances described in the notice of Privacy Practices.

X Signature: _____Date:___ /___ /____ Relationship: Self Parent Other

I authorize the release for information to:

Name: _____ Relationship: _____Date:__ /___/___

Name: _____ Relationship: _____Date:__ /___/___

Name: _____ Relationship: _____Date:__ /___/___