Patient Account Number: ______________________

Patient Demographic

Personal Information

First Name: ______________________________ **Middle Initial:** _________ **Last Name:** ______________________________

Mailing Address: ____**City:**________________ **State:**_____ **Zip Code:**________

Street Address: ____**City:**________________ **State:**_____ **Zip Code:**________

Date of Birth: _____/_____/________ **Age:** ________ **Gender:** **Male** **Female** **(Circle One)**

Social Security Number: ________ - ________ - ________

Race: _________________________________ **Ethnicity:** Not Hispanic or Latino / Hispanic or Latino **(Circle One)**

Primary Language: _________________________________

Preferred Contact

Home Phone Number: (_____) ________ **-** _______ **Mobile Phone Number: (_____)** ________ **-** ________

Appointment Reminder Method: Phone call or Mobile Text (**Circle One**)

Is it okay to leave voicemail messages: **YES or** NO **(Circle One)**

Email: ____

I understand that email is not a secure method of communication and that personal health information, payment receipt, Invoices and billing summary sent via email may not be private.

Status

Marital		Employment		Student Status		How did you hear about us?
	Single		**Full Time**		**Full Time Student**		**Friend/Family**
	Married		**Part Time**		**Part Time Student**		**Doctor**
	Divorced		**Retired**				**Website**
	Widowed		**Self Employed**				**Social Media**
	Separated		**Not Employed**				**Other**

Guardian/Responsible Party Info

First Name: ______________________________ **Middle Initial:** _________ **Last Name:** ______________________________

Mailing Address: ____**City:**________________ **State:**_____ **Zip Code:**________

Date of Birth: _____/_____/________ **Relation to Patient:** ______________________________

Emergency Contact

First Name: ___________________________ **Last Name:** ____

Relationship: __________________________ **Phone Number:** ____

Patient Account Number: ________________________

Patient Insurance Information

First Name: ________________________________ **Middle Initial:** __________ **Last Name:** ________________________________

Primary Insurance Information

Insurance Company Name: ________________________________

Name of Insured: ________________________________

Relationship to Patient: ________________________________

Date of Birth: _____/_____/_________

Policy Number: _____________________

Group Number: _____________________

Secondary Insurance Information

Insurance Company Name: ________________________________

Name of Insured: ________________________________

Relationship to Patient: ________________________________

Date of Birth: _____/_____/_________

Policy Number: _____________________

Group Number: _____________________

Vision Insurance Information

Insurance Company Name: ________________________________

Name of Insured: ________________________________

Relationship to Patient: ________________________________

Date of Birth: _____/_____/_________

Policy Number: _____________________

Social Security Number: ______ - ______ - ______

Patient Account Number: ________________________

MEDICAL HISTORY

Preferred Pharmacy: ____

Address: ____ City: __________________________ State: _________________

Zip: ____________________ Phone: ___________________________________ Fax: __________________________________

ALLERGIES AND MEDICATIONS

Allergies:
____

____

Please bring a list of all current medications and dosages with you to your appointment.

Dr. Lewis J. Frazee, M.D. – Dr. Ellen Ngo, M.D. – Dr. James Passmore, M.D.

Patient Account Number: ___________________________

Who is your primary care physician? ____

If you have a Rheumatologist, who is it? ____

If you have an Endocrinologist, who is it? ____

Who has referred you to our office today? ____

FAMILY HISTORY:

No significant family history ☐

	FATHER	MOTHER	SISTER	BROTHER
Diabetes	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐
Macular degeneration	☐	☐	☐	☐
Retinal detachment	☐	☐	☐	☐
Blindness	☐	☐	☐	☐

ALCOHOL USAGE:

None ☐ Occasionally/Social ☐
1-2 Drinks/day ☐ 3 or more Drinks/day ☐

TOBACCO USAGE:

☐ Never Smoked
☐ Former Smoker
☐ Current Every day Smoker
☐ Current Some Day Smoker

If smoker, smoking history is: ________ packs per day for how long ________________

Patient Account Number: ______________________

GENERAL MEDICAL HISTORY:

	YES	NOTES
Patient denies any history of medical conditions or diseases	☐	______
CARDIOVASCULAR		
Congestive heart failure	☐	______
Coronary artery disease	☐	______
Elevated cholesterol	☐	______
Heart attack	☐	______
Heart valve disease	☐	______
Hypertension	☐	______
Pacemaker	☐	______
Other cardiovascular	☐	______
DERMATOLOGIC		
Keloid formation	☐	______
Shingles	☐	______
Skin cancer	☐	______
Other dermatologic	☐	______
GASTROINTESTINAL		
Colon cancer	☐	______
Crohn’s	☐	______
GI bleeding	☐	______
Ulcerative colitis	☐	______
Other gastrointestinal	☐	______
GENITOURINARY		
Enlarged prostate	☐	______
Kidney disease	☐	______
Other genitourinary	☐	______
HEMATOLOGIC		
Anemia	☐	______
Bleeding disorder	☐	______
Blood clots	☐	______
Leukemia	☐	______
Sickle cell	☐	______
Other hematologic	☐	______

Patient Account Number: ______________________

	YES	NOTES
INFECTIOUS DISEASE		
Hepatitis C	☐	____________
HIV	☐	____________
MRSA	☐	____________
Tuberculosis	☐	____________
Other infectious disease	☐	____________
METABOLIC/ENDOCRINE		
Diabetes, Type I	☐	____________
Diabetes, Type II	☐	____________
Thyroid disease	☐	____________
Other metabolic/endocrine	☐	____________
MUSCULOSKELETAL		
Gout	☐	____________
Osteoarthritis	☐	____________
Rheumatoid arthritis	☐	____________
Other musculoskeletal	☐	____________
NEUROLOGICAL		
Dementia	☐	____________
Migraines	☐	____________
Multiple sclerosis	☐	____________
Seizures	☐	____________
Stroke	☐	____________
Other neurological	☐	____________
PULMONARY		
Asthma	☐	____________
COPD	☐	____________
Lung cancer	☐	____________
Sarcoid	☐	____________
Sleep apnea	☐	____________
Other lung disease	☐	____________
PSYCHIATRIC		
Anxiety	☐	____________
Bipolar	☐	____________
Depression	☐	____________
Schizophrenia	☐	____________
Other psychiatric	☐	____________

Patient Account Number: ___________________________

	YES	NOTES
WOMEN'S HEALTH		
Breast Cancer	☐	___________________________
Ovarian cancer	☐	___________________________
Other women's health	☐	___________________________

PAST EYE SURGERIES:	YES	NOTES
1. LASIK	☐	___________________________
2. PRK	☐	___________________________
3. RK	☐	___________________________
4. Corneal Transplant	☐	___________________________

PAST SURGICAL HISTORY:

SURGERY DETAILS **DATE**

1.____
2.____
3.____
4.____
5.____
6.____
7.____
8.____
9.____
10.____