Today's Date_____ Patient Name:_____
First Last MI

Patient's Social Security #:_____ Patient's Birth date:_____/_____/_____
Month Day Year

Patient's Address:_____
Street City State Zip

Phone # _____ _____ _____
Home Work Cell

Sex: □ M □ F □ Married □ Widowed □ Single □ Minor □ Separated □ Divorced □ Partnered

Occupation:_____ Employer:_____

Spouse's Name:_____ Spouse's Work#_____

Please give our receptionist any major medical or eye insurance cards for us to photocopy:
We are happy to see you for your visit today. We would like to inform you that without the proper insurance information, we cannot verify that your fees will be paid for by insurance. The entire balance will be your financial responsibility.

I certify that I, and/or my dependent(s) have insurance coverage that I presented and assign directly to Drs. Brockman & Tsao all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I authorize the disclosure of my health care information as needed to process these claims.

X_____

Year of last eye exam and name of Doctor:_____ □ none

Year of last medical exam and name of Doctor:_____ □ none

We can photocopy a list of your medications or obtain a list from your physician if you prefer:

Medication (include vitamins)	**Strength / Dose**	**# pills per day**	**The reason you are taking this medication:**

Allergies to medications: □ **none**	Mild , Moderate, or Severe reaction: please describe	

□ Please turn page over and complete other side ⟶

Please list any surgeries you have had (including chemotherapy): □ none

_____

_____

_____

Which pharmacy do you prefer : _____

Check if you or a family member have:

	self	which relative (if any)
high blood pressure	□	_____
diabetes	□	_____
high cholesterol	□	_____
heart disease	□	_____
cataracts	□	_____
glaucoma	□	_____
macular degeneration	□	_____

other: _____

_____

Check if you have:

□ food or environmental allergies
□ indigestion
□ headache
□ migraine
□ arthritis
□ sinus congestion
□ thyroid problems
□ recent weight loss or gain
□ shortness of breath
□ anxiety or depression

□ Hepititis □A □B □C
□ HIV / Aids

Any additional information that you would like the Doctor to be aware of:

Number of dependent children: _____ Number of adult children: _____ □ Check box if pregnant or nursing

When did you start smoking: □ never □ year smoking began _____ □ year smoking ended _____ □ current smoker

Do you drink alcohol: □no □ less than 1 drink per day □ 1-2 per day □ more than 3 drinks per day

How did you hear about our office?_____

Your primary reason for today's visit is: _____
email address (this will only be used to confirm appointments, etc. and will never be shared):

_____

Person to contact in case of emergency:

Name_____
Address_____

_____
Phone_____
Relationship to you_____