

WELCOME TO OUR OFFICE

Patient Name _____ Date of Birth _____ Social Security Number _____
Address _____

Home Phone _____ mailing _____ city _____ state _____ zip _____
Work Phone _____ Cell Phone _____
Occupation _____ Next of kin _____ relation _____

Health insurance company _____ Vision insurance _____
If you have Medicare Part B, who is supplement company? _____
Employer _____ Group # _____ Employee name _____

I authorize the payment of medical benefits to the physician whose name and address appear below:

Patient signature _____ Date _____
I have received a copy of Dr. Huddleston's privacy practices Initial _____

PERSONAL MEDICAL INFORMATION (use lines at bottom for additional comments)

Please list your regular medications with dosages and how often you take them _____

What drugs are you allergic to and what effect does it have? _____

Are you diabetic? Y/N Type _____ Do you have headaches? Y/N _____

Have you had surgeries? What kind and when? _____

Do you use tobacco? Y/N Alcohol? Y/N Other substances? _____

Do you have problems with any of the following (circle all that apply) eyes Y/N

Digestive system? Y/N Nervous system? Y/N Mental? Y/N Breathing? Y/N

Heart problems? Y/N Ears/Nose/Throat? Y/N Bones/Muscles? Y/N Blood? Y/N

Skin? Y/N Glandular problems? Y/N Allergic/immune problems? Y/N

Explain briefly _____

Family doctor _____ Last seen? _____ May we send a report of your visual condition? Y/N

Patient's signature _____ Date _____

PERSONAL EYE INFORMATION.

Have you had any eye injury, operations, or ocular medical conditions since your last eye exam? Y/N
What kind? _____

Do you wear contact lenses? If so, what kind? _____

Other eye concerns you want the doctor to address? _____

FAMILY HISTORY

Has anyone in your family (blood relation) had any of the following conditions? (circle all that apply)
Diabetes Macular degeneration Glaucoma Retinal detachment Other? _____

We would like to thank those who may have recommended us to you. Whom should be thank for your visit?
