**Raleigh Optometry**
Dr. P. Wayne Moser
Dr. Donathan G. Hudgins

# New Patient Information

**PATIENT INFORMATION –** *Please print clearly.*

| Patient's name & relationship (if not you) | Address | Phone |
|---|---|---|
| | | |

| Date of birth | Age | Sex | Marital Status | Email address |
|---|---|---|---|---|
| | | ☐ M ☐ F | ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed | |

| Occupation | Employer | Work phone |
|---|---|---|
| | | |

| Have you had any eye operations? | Do you wear glasses? | Do you wear contact lenses? | Are you interested in wearing contacts? |
|---|---|---|---|
| ☐ Y ☐ N Date: | ☐ Y ☐ N | ☐ Y ☐ N Type: | ☐ Y ☐ N |

| Last eye exam | Last eye doctor | Reason for today's exam |
|---|---|---|
| | | |

If any other members of your family have been examined at this office, please give their name(s) and their relationship to you.

| Whom may we thank for referring you? | Person to contact in case of an emergency. Phone: Relationship: |
|---|---|
| | |

## MEDICAL HISTORY

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ☐ | ☐ | Diabetic retinopathy (blindness) | ☐ | ☐ | High blood pressure |
| ☐ | ☐ | Cataracts | ☐ | ☐ | Gastrointestional (reflux, ulcers, intestinal disease) |
| ☐ | ☐ | Amblyopia (turned or lazy eye) | ☐ | ☐ | Kidney disease (kidney stones, dialysis) |
| ☐ | ☐ | Glaucoma | ☐ | ☐ | Cancer (type or location) _____ |
| ☐ | ☐ | Eye injury (date/nature) _____ | ☐ | ☐ | Ear, Nose, Throat (hearing loss, sinus) |
| ☐ | ☐ | Retinal detachment | ☐ | ☐ | Thyroid (hypo, hyper, graves) |
| ☐ | ☐ | Retinal disease | ☐ | ☐ | Heart (angina, arrhythmia, heart failure, heart attack) |
| ☐ | ☐ | Macular degeneration ☐ Wet ☐ Dry | ☐ | ☐ | Psychiatric (anxiety, depression, bipolar, schizophrenic) |
| ☐ | ☐ | Arthritis | ☐ | ☐ | Lungs (bronchitis, asthma, emphysema, COPD) |
| ☐ | ☐ | Blood problems (clotting, anemia, leukemia) | ☐ | ☐ | Stroke, Seizures, Paralysis |
| ☐ | ☐ | Diabetes (give type) _____ | ☐ | ☐ | Infectious disease (hepatitis, TB, malaria, syphilis, gonorrhea, AIDS, HIV) |

Prescription drugs _____

Prescription drug allergies _____

Previous surgeries: Date/Reason _____

## FAMILY HISTORY

| | Father | Mother | Brother | Sister | Other | | Father | Mother | Brother | Sister | Other |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Diabetes | ☐ | ☐ | ☐ | ☐ | ☐ | Heart disease | ☐ | ☐ | ☐ | ☐ | ☐ |
| Retinal disease | ☐ | ☐ | ☐ | ☐ | ☐ | High blood pressure | ☐ | ☐ | ☐ | ☐ | ☐ |
| Glaucoma | ☐ | ☐ | ☐ | ☐ | ☐ | Cancer | ☐ | ☐ | ☐ | ☐ | ☐ |

## INSURANCE INFORMATION - *Please present your insurance cards to the receptionist with this form.*

| PRIMARY (Vision) - Name of insurance | Insured's FULL name | Member ID no. | Group no. |
|---|---|---|---|
| | | | |
| SECONDARY - Name of insurance | Insured's FULL name | Member ID no. | Group no. |
| | | | |

I plan to pay my medical expenses as follows: ☐ Cash/Check ☐ MasterCard ☐ Visa ☐ Discover Card

**Financial Agreement and Authorization for Treatment:** I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family. I agree that payments will not be delayed because of insurance coverage and all proceeds of insurance are assigned to this office where applicable.

Signature _____ Date_____
Person responsible for payment