

# Talley Eye Institute

Demographic and Insurance Information  
www.talleyeyeinstitute.com

Name: \_\_\_\_\_ Today's Date: \_\_\_/\_\_\_/\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ E-Mail: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_ Sex:  M  F

Marital Status:  Single  Married  Divorced  Separated  Widowed Social Security No.: \_\_\_\_\_

Race:  White  American Indian/Alaska Native  Asian  Black/African American  Hispanic/Latino  Native Hawaiian/Other Pacific Islander

Ethnicity:  Hispanic/Latino  Non-Hispanic/Latino

Language Preference:  English  Spanish  Other \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Notify in case of emergency: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_ Date of last doctor visit: \_\_\_/\_\_\_/\_\_\_

Referring Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Is this a Workers' Comp injury?  Yes  No If YES, what is the nature of the injury? \_\_\_\_\_

Date of Injury: \_\_\_/\_\_\_/\_\_\_ Has the accident been reported to your employer?  Yes  No

Employer Name: \_\_\_\_\_ Employer Address: \_\_\_\_\_

Employer Phone: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Is this an Auto Liability Accident injury?  Yes  No If YES, what is the nature of the injury? \_\_\_\_\_

Where were you when injury/accident occurred? \_\_\_\_\_

What were you doing when injury/accident took place? \_\_\_\_\_

Auto Insurance Company Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Claim Number (if known): \_\_\_\_\_

## RESPONSIBLE PARTY'S INFORMATION (if a Minor, Guardian or Power of Attorney)

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Social Security No.: \_\_\_\_\_

## PRIMARY INSURANCE INFORMATION

Name of Insurance: \_\_\_\_\_ Name of Cardholder: \_\_\_\_\_

ID#: \_\_\_\_\_ Cardholder's Social Security No.: \_\_\_\_\_ Cardholder's Birthdate \_\_\_/\_\_\_/\_\_\_

Relationship to patient: \_\_\_\_\_ Cardholder's Employer: \_\_\_\_\_

## SECONDARY INSURANCE INFORMATION

Name of Insurance: \_\_\_\_\_ Name of Cardholder: \_\_\_\_\_

ID#: \_\_\_\_\_ Cardholder's Social Security No.: \_\_\_\_\_ Cardholder's Birthdate \_\_\_/\_\_\_/\_\_\_

Relationship to patient: \_\_\_\_\_ Cardholder's Employer: \_\_\_\_\_

I understand that, even though I may have some type of insurance and authorize this office to submit charges on my behalf, I am also responsible for payment. I hereby assign to the doctor, all payments for medical services rendered to me. I am aware that a co-payment may be required at each visit, and if there is no insurance coverage, payment in full is required for services unless prior payment arrangements have been discussed. I will also be responsible for all collection fees, should my account be assigned to a collection agency.

Signature \_\_\_\_\_ Date \_\_\_\_\_

# Talley Eye Institute

Medical and History Record  
www.talleyeyeinstitute.com

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Name: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

## PRESENT ILLNESS

Do you currently have any problems in the following areas?

	YES	NO		YES	NO		YES	NO
EYES								
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	Excessive tearing/watering	<input type="checkbox"/>	<input type="checkbox"/>	Are you having any difficulty?		
Loss of vision	<input type="checkbox"/>	<input type="checkbox"/>	Infection of eye/eyelid	<input type="checkbox"/>	<input type="checkbox"/>	Reading small print	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	Dryness	<input type="checkbox"/>	<input type="checkbox"/>	Driving at night	<input type="checkbox"/>	<input type="checkbox"/>
Fluctuating vision	<input type="checkbox"/>	<input type="checkbox"/>	Redness	<input type="checkbox"/>	<input type="checkbox"/>	Halos around headlights	<input type="checkbox"/>	<input type="checkbox"/>
Glare/light sensitive	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>	Reading traffic lights	<input type="checkbox"/>	<input type="checkbox"/>
Mucous discharge	<input type="checkbox"/>	<input type="checkbox"/>	Eye pain/soreness	<input type="checkbox"/>	<input type="checkbox"/>	Doing hobbies	<input type="checkbox"/>	<input type="checkbox"/>
Eye irritation	<input type="checkbox"/>	<input type="checkbox"/>	Stye, chalazion	<input type="checkbox"/>	<input type="checkbox"/>	Watching TV	<input type="checkbox"/>	<input type="checkbox"/>

Are you currently having any problems in the following areas OR ever been treated for?

	CURRENT	PAST		CURRENT	PAST		CURRENT	PAST
Constitutional			Gastrointestinal			Respiratory		
childbirth	<input type="checkbox"/>	<input type="checkbox"/>	gastric reflux/GERD	<input type="checkbox"/>	<input type="checkbox"/>	asthma	<input type="checkbox"/>	<input type="checkbox"/>
fever	<input type="checkbox"/>	<input type="checkbox"/>	colon cancer	<input type="checkbox"/>	<input type="checkbox"/>	COPD	<input type="checkbox"/>	<input type="checkbox"/>
obesity	<input type="checkbox"/>	<input type="checkbox"/>	stomach ulcers	<input type="checkbox"/>	<input type="checkbox"/>	emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (Skin)			nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	lung cancer	<input type="checkbox"/>	<input type="checkbox"/>
breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary			sarcoidosis	<input type="checkbox"/>	<input type="checkbox"/>
skin cancer	<input type="checkbox"/>	<input type="checkbox"/>	cervical cancer	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine		
Musculoskeletal			uterine cancer	<input type="checkbox"/>	<input type="checkbox"/>	diabetes	<input type="checkbox"/>	<input type="checkbox"/>
muscle/joint pain	<input type="checkbox"/>	<input type="checkbox"/>	kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	pancreatic cancer	<input type="checkbox"/>	<input type="checkbox"/>
lupus	<input type="checkbox"/>	<input type="checkbox"/>	prostate cancer	<input type="checkbox"/>	<input type="checkbox"/>	thyroid cancer	<input type="checkbox"/>	<input type="checkbox"/>
osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	prostate hypertrophy	<input type="checkbox"/>	<input type="checkbox"/>	thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Neurological			weight loss	<input type="checkbox"/>	<input type="checkbox"/>
Ears, Nose, Throat			migraines	<input type="checkbox"/>	<input type="checkbox"/>	weight gain	<input type="checkbox"/>	<input type="checkbox"/>
difficulty hearing	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	Hematologic/Lymphatic		
ear pain	<input type="checkbox"/>	<input type="checkbox"/>	seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>	anemia	<input type="checkbox"/>	<input type="checkbox"/>
nasal congestion	<input type="checkbox"/>	<input type="checkbox"/>	stroke/CVA	<input type="checkbox"/>	<input type="checkbox"/>	bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>
nasal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular			blood cancer	<input type="checkbox"/>	<input type="checkbox"/>
chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	leukemia	<input type="checkbox"/>	<input type="checkbox"/>
dry throat/mouth	<input type="checkbox"/>	<input type="checkbox"/>	congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	sickle cell disease	<input type="checkbox"/>	<input type="checkbox"/>
Allergic/Immunologic			heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric		
hay fever symptoms	<input type="checkbox"/>	<input type="checkbox"/>	heart disease	<input type="checkbox"/>	<input type="checkbox"/>	anxiety	<input type="checkbox"/>	<input type="checkbox"/>
immune problems	<input type="checkbox"/>	<input type="checkbox"/>	high cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	depression	<input type="checkbox"/>	<input type="checkbox"/>
seasonal allergies	<input type="checkbox"/>	<input type="checkbox"/>	irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>	dementia	<input type="checkbox"/>	<input type="checkbox"/>

Other Past/Present Conditions: \_\_\_\_\_

## PAST OCULAR HISTORY

<input type="checkbox"/> No significant illnesses	<input type="checkbox"/> corneal ulcer	<input type="checkbox"/> eyelid turned inward	<input type="checkbox"/> glaucoma	<input type="checkbox"/> nerve palsy
<input type="checkbox"/> Bell's palsy	<input type="checkbox"/> diabetic retinopathy	<input type="checkbox"/> eyelid turned outward	<input type="checkbox"/> herpes	<input type="checkbox"/> ocular allergies
<input type="checkbox"/> cataract	<input type="checkbox"/> double vision	<input type="checkbox"/> foreign body removed	<input type="checkbox"/> iritis	<input type="checkbox"/> pterygium
<input type="checkbox"/> chalazion/stye	<input type="checkbox"/> dry eye syndrome	<input type="checkbox"/> Fuchs' dystrophy	<input type="checkbox"/> lazy eye (amblyopia)	<input type="checkbox"/> retinal detachment
<input type="checkbox"/> corneal laceration/scratch			<input type="checkbox"/> macular degeneration	<input type="checkbox"/> uveitis
<input type="checkbox"/> Other _____				

## PAST OCULAR SURGERY

<input type="checkbox"/> No prior eye surgery	<input type="checkbox"/> corneal surgery	<input type="checkbox"/> eyelid surgery	<input type="checkbox"/> laser eye surgery	<input type="checkbox"/> pterygium surgery
<input type="checkbox"/> cataract surgery	<input type="checkbox"/> eye muscle surgery	<input type="checkbox"/> glaucoma surgery	<input type="checkbox"/> LASIK/refractive surgery	<input type="checkbox"/> retinal surgery
<input type="checkbox"/> Other _____				

## OTHER PAST SURGERY

<input type="checkbox"/> No prior surgery	<input type="checkbox"/> carotid surgery	<input type="checkbox"/> heart surgery	<input type="checkbox"/> kidney surgery	<input type="checkbox"/> orthopedic surgery
<input type="checkbox"/> appendectomy	<input type="checkbox"/> colon surgery	<input type="checkbox"/> hip surgery	<input type="checkbox"/> lung surgery	<input type="checkbox"/> pacemaker
<input type="checkbox"/> back surgery	<input type="checkbox"/> coronary artery bypass	<input type="checkbox"/> hysterectomy	<input type="checkbox"/> lymph node surgery	<input type="checkbox"/> stomach surgery
<input type="checkbox"/> brain surgery	<input type="checkbox"/> dental surgery	<input type="checkbox"/> implanted defibrillator	<input type="checkbox"/> mastectomy	<input type="checkbox"/> thyroid surgery
<input type="checkbox"/> breast surgery	<input type="checkbox"/> gallbladder	<input type="checkbox"/> intestine surgery	<input type="checkbox"/> nose surgery	<input type="checkbox"/> tonsillectomy
<input type="checkbox"/> Other _____				<input type="checkbox"/> tumor removed

## PAST INFECTION HISTORY

- |                                      |                                      |   |  |                                       |
|--------------------------------------|--------------------------------------|---|--|---------------------------------------|
| <input type="checkbox"/> None        | <input type="checkbox"/> Chlamydia   | <input type="checkbox"/> Hepatitis C    | <input type="checkbox"/> Histoplasmosis  | <input type="checkbox"/> STD          |
| <input type="checkbox"/> AIDS        | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Herpes Simplex | <input type="checkbox"/> HIV             | <input type="checkbox"/> Syphilis     |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Herpes Zoster  | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Other _____ |                                      |   |  |                                       |

## FAMILY HISTORY

	YES	NO	RELATIONSHIP TO PATIENT		YES	NO	RELATIONSHIP TO PATIENT
<input type="checkbox"/> blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____	retinal detachment	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> heart attack	<input type="checkbox"/>	<input type="checkbox"/>	_____	cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> cataract	<input type="checkbox"/>	<input type="checkbox"/>	_____	stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> heart problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	Fuchs' dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

## SOCIAL HISTORY

	YES	NO	
Do you currently wear glasses?	<input type="checkbox"/>	<input type="checkbox"/>	How long have you had the current pair? <input type="checkbox"/> weeks <input type="checkbox"/> months <input type="checkbox"/> years
Do you currently wear contacts?	<input type="checkbox"/>	<input type="checkbox"/>	What type of contacts? <input type="checkbox"/> hard <input type="checkbox"/> soft <input type="checkbox"/> gas permeable
Have you ever tried to wear contacts?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you drive?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you use illegal drugs?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you a <input type="checkbox"/> current every day smoker			How many packs per day? _____
<input type="checkbox"/> former smoker			When did you quit? _____
<input type="checkbox"/> never smoker			
What is your occupation?	_____		
If retired, what was your occupation?	_____		

## MEDICATIONS

List all current medications you are taking (includes prescription, over-the-counter, herbals, vitamins, mineral supplements, dietary supplements). Attach a list if necessary.

Name: _____	Dosage: _____	How often? _____
By <input type="checkbox"/> mouth <input type="checkbox"/> inject <input type="checkbox"/> patch <input type="checkbox"/> _____	Prescribing Doctor: _____	Taken for? _____
Name: _____	Dosage: _____	How often? _____
By <input type="checkbox"/> mouth <input type="checkbox"/> inject <input type="checkbox"/> patch <input type="checkbox"/> _____	Prescribing Doctor: _____	Taken for? _____
Name: _____	Dosage: _____	How often? _____
By <input type="checkbox"/> mouth <input type="checkbox"/> inject <input type="checkbox"/> patch <input type="checkbox"/> _____	Prescribing Doctor: _____	Taken for? _____
Name: _____	Dosage: _____	How often? _____
By <input type="checkbox"/> mouth <input type="checkbox"/> inject <input type="checkbox"/> patch <input type="checkbox"/> _____	Prescribing Doctor: _____	Taken for? _____
Name: _____	Dosage: _____	How often? _____
By <input type="checkbox"/> mouth <input type="checkbox"/> inject <input type="checkbox"/> patch <input type="checkbox"/> _____	Prescribing Doctor: _____	Taken for? _____
Name: _____	Dosage: _____	How often? _____
By <input type="checkbox"/> mouth <input type="checkbox"/> inject <input type="checkbox"/> patch <input type="checkbox"/> _____	Prescribing Doctor: _____	Taken for? _____

What pharmacy do you use? \_\_\_\_\_ pharmacy phone: \_\_\_\_\_

Do you have allergies to any medications?  Yes  No

If YES, list medications and the reaction to them (includes difficulty breathing, confusion, cough, dizziness, swelling of limbs, headache, lethargy, nausea/vomiting, hives/rash)

\_\_\_\_\_

Have you ever had a reaction to anesthetic?  Yes  No

Do you currently or have you ever used Flomax (Tamsulosin)?  Yes  No

Have you ever had a blood transfusion?  Yes  No

Are you allergic to latex?  Yes  No

Do you have MRSA/VRE?  Yes  No