

Patient Information

Today's Date:			
Your Name:		Email:	
Street:		City:	State: Zip:
Home Phone:	Work Phone:	Cell Phone:	
Birth Date:	Sex: M F	Age:	Marital Status: S M D W
Social Security Number:		Referred By:	
Employer/School:			
Primary Care Doctor (PCP):		Phone:	
Emergency Contact Name:		Phone:	
Medical Insurance:		ID#:	Group#:
Policy Holder's Name:		Date of Birth:	
Vision Insurance:		Ins. #:	
Policy Holder's Name:		Date of Birth:	
<p>I hereby authorize payment of benefits per appropriate assignment(s) above to Martinelli Eye & Laser Centers and/or its physicians rendering services, not to exceed the balance due of any before mentioned provider's regular charges for the period. I understand that I am financially responsible to the physician for charges not covered by this authorization.</p>			
Signature:		Date:	

Patient History

Date of Birth:	Date of Last Exam:		
List any medications you currently take (RX & Over the Counter)			
Do you have allergies to any medications (circle one):	YES	NO	
If YES, please list the medications:			
List any major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.):			
List any surgeries you have had (cataract, appendectomy):			
Do you currently have any problems in the following areas? If YES , please provide additional information below.			
	YES	NO	Details
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL/CONSTITUTIONAL (fever, heat strokes, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES – Are you pregnant? Nursing?			
MUSCLES, BONES JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD/LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

Family History – Has any member of your family had these diseases (circle all that apply)	Mother, Father, Grandparent, Sibling		
	YES	NO	Unknown
Blindness, Cataract, Glaucoma, diabetes, Hypertension, Heart disease, Stroke. Cancer, Thyroid disease, Arthritis, other heritable disease:			
Social History (check one)	YES	NO	
Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)?			
Have you ever had a blood transfusion?			
Do you Drink Alcohol?			
If YES, how much?			
Do you smoke?			
If YES, how much?	How many years?		
Physician's Signature:		Date:	

Patient Acknowledgement & Authorization

Please Initial:	
	I acknowledge that I have received or was offered the practice's Privacy Policy describing the use and disclosure of confidential healthcare information.
	I authorize the release of my medical records to Martinelli Eye & Laser Centers upon its request, including all examinations, diagnoses, laboratory/imaging studies and treatments.
	I authorize Martinelli Eye & Laser Centers to provide my insurance company with information regarding services rendered.
	I authorize payment of my medical/vision benefits to Martinelli Eye & Laser Centers for services rendered.
	I understand and agree that I am financially responsible for all charges for services rendered to me, including balances owed after insurance payments, as well as deductibles and/or co-payments.
If Non-Routine or Additional Testing is Required, Please Check One:	
	YES , I hereby authorize Martinelli Eye & Laser Centers to perform additional testing/procedures if deemed necessary by the doctor. I understand that certain additional testing/procedures may or may not be reimbursable by my insurance carrier(s).
	NO , In the event additional testing is deemed necessary, I refuse additional testing as recommended by the doctor and hereby release him/her from any liability resulting from my decision.
Signature:	
Date:	
Print Name:	