MARTINELLI EYE & LASER CENTERS

Patient's Name: _____ **EMAIL**:_____
To receive appointment reminders, upcoming specials, etc

Birth Date: _____ Age: _____ Sex: M F Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number - Home: _____ Work: _____ Cell: _____

Referred By: _____Employer/School: _____ Marital Status: S M D W

Emergency Contact:_____Relationship:_____ Phone #_____
.

Primary Care Physician: _____ Phone: _____Location: _____

Pharmacy: _____ Phone: _____ Location: _____

Please check ALL that apply:

	Wear glasses		Anemia		Pregnant		Dry mouth
	Wear contact lenses		Anxiety		Nursing		Hard of hearing
	Have eye pain		Depression		Joint pain/swelling		Fever
	Tearing		Thyroid		Fibromyalgia		Excessive weight loss/gain
	Redness		Hernia		Arthritis		Chronic fatigue
	Light sensitivity		Ulcers		Numbness/tingling arm or leg		Sneezing
	Glaucoma Family History (Hx): Y N		Diarrhea		Seizures		Itching
	Cataracts Family Hx: Y N		Constipation		Stoke/ TIA		Hives
	Diabetes Family Hx: Y N		Impotence		Headaches		Wheezing
	Macular Degeneration Family Hx: Y N		Painful urination		Sinus pain/pressure		Chest congestion
	Heart problems		Frequent urination		Earache		Short of breath
	Hypertension		Jaundice		Cough		Other:

List any **medications** you currently take(Rx and over-the counter):_____

Do you have any **allergies** to medications? YES NO if yes please list:_____

List any surgeries you have had (cataract, appendectomy, etc.)_____

Medical Insurance: _____ ID #: _____Group # _____

Policy Holder's Name: _____ Birth Date: _____ Relationship: _____

Vision Insurance: _____ ID # _____

Policy Holder's Name: _____ Birth Date: _____Relationship: _____

I hereby authorize payment of insurance benefits per appropriate assignment(s) to Martinelli Eye & Laser Centers and/or the physicians rendering services, including any additional testing the physician deems necessary, not to exceed the balance due of any aforementioned providers' regular charges for the period. I authorize Martinelli Eye and Laser Centers to provide my insurance company with any information regarding services/tests rendered to me in order to process my claim. I understand that I am financially responsible to Martinelli Eye and Laser Centers for charges not covered by my insurance policy or this authorization.

☐ I acknowledge that I received or was offered the practice's Privacy Policy regarding confidential health information.

Signature: _____Relationship if minor_____ Date:_____

THANK YOU & WELCOME TO OUR PRACTICE!