Canton Ophthalmology Associates, Inc.
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PATIENT INFORMATION

To better serve you, we have converted to an electronic medical record (EMR) system. Due to regulations governing this type of system, there is pertinent data that we must obtain on every patient that is required to be included in their electronic medical record. Be assured that this information is protected by our HIPAA Privacy Practices (the same as a paper chart) and is further protected by the computer security protocols required for electronic health records.

Today's date: _____ **PLEASE PRINT OR WRITE CLEARLY AND READABLY IN BLUE OR BLACK INK.**

FULL LEGAL NAME OF PATIENT:

First:_____ Middle initial: _____ Last:_____

Street Address: _____

City: _____ State: _____ Zip code: _____

Phone #'s: (home - landline) _____ (Cell) _____

E-mail: _____

Date of birth**: _____ SSN: _____ ☐ Male ☐ Female

If this patient is a minor or still covered under their parent or guardian's insurance, you will need to complete the "Guarantor Information" section on the next page.

Marital Status: ☐ Married ☐ Widowed ☐ Divorced ☐ Single

Race (check one): □American Indian or Alaska Native □ Asian □ Black or African American
□ Native Hawaiian or other Pacific Islander □ Other race □ White

Ethnicity (check one): □ Hispanic or Latino □ Not Hispanic or Latino

Preferred language (check one): □ English □ Other (specify): _____

Patient's employment status: ☐ Full time ☐ Part time ☐ Retired ☐ Disabled ☐ Not employed

Patient's employer: _____ Address: _____

Patient's work phone # _____ Occupation: _____

If married: Spouse's name: _____

Spouse's Social Security No. _____ Date of birth: _____

Spouse's employment status: ☐ Full time ☐ Part time ☐ Retired ☐ Disabled ☐ Not employed

Spouse's employer: _____ Address: _____

Spouse's work phone # _____ Occupation: _____

Emergency contact (*person not currently living with patient*):

First & last name _____

Relationship to patient (e.g. sister, friend): _____ Phone # _____

Does patient currently have tuberculosis (TB)? ☐ No ☐ Yes➔ ☐ Active ☐ Inactive
Date diagnosed: _____
On any TB medication? ☐ No ☐ Yes ➔ specify: _____

~PLEASE TURN OVER FOR ADDITIONAL INFORMATION NEEDED~

GUARANTOR INFORMATION

✶**If patient is a minor or still covered under parent/guardian's insurance**, please complete this section:

Mother's name: ______________________________

Mother's address: ______________________________
(if different from patient's address)

Mother's phone #'s: (home landline) ____________ (Cell) ____________

Mother's Social Security no. ____________ Date of birth: ____________

Mother's employer: ____________ Work phone # ____________

Mother's employment status: ☐ Full time ☐ Part time ☐ Retired ☐ Unemployed

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Father's name: ______________________________

Father's address: ______________________________
(if different from patient's address)

Father's phone #'s: (home landline) ____________ (Cell) ____________

Father's Social Security no. ____________ Date of birth: ____________

Father's employer: ____________ Work phone # ____________

Father's employment status: ☐ Full time ☐ Part time ☐ Retired ☐ Unemployed

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Guardian (if **not** mother or father): Name: ______________________________

Guardian's relationship to patient (e.g. grandparent, foster parent): ____________

Guardian's address: ______________________________
(if different from patient's address)

Guardian's phone #'s (home landline) ____________ (Cell) ____________

Guardian's Social Security no. ____________ Date of birth: ____________

Guardian's employer: ____________ Work phone # ____________

Patient referred to Canton Ophthalmology by: ______________________________

Primary Care Physician (family physician) name: ______________________________

PCP's phone # ____________ Office location: ____________

Optometrist (O.D.): ____________ Phone # ____________

Does patient see any other physician specialists (e.g. endocrinologist for diabetes, cardiologist)? ◻ No ◻ Yes▶

1. Specialist name: ____________ Office location: ____________

   Phone # ____________ Specialty: ____________

2. Specialist name: ____________ Office location: ____________

   Phone # ____________ Specialty: ____________

Health Insurance Information: *Please present insurance card(s) to be copied.*
If card(s) not available, an additional Insurance Information form must be completed.

Does patient have routine vision care (non-medical) insurance coverage?
☐ No ☐ Yes (specify name of insurance, e.g. VSP, Eyemed, Spectera): ____________

Thank you!

Medical History

Patient name: _____ Date of birth: _____

Appointment date: _____

To save time on your appointment day, please provide the following information. When returning this to our office, please allow sufficient time for this to arrive in our office at least 2 business days prior to your visit.

Ocular (eye) history (e.g. glaucoma, lazy eye, macular degeneration): _____

_____

Past ocular (eye) procedures (e.g. cataract surgery, LASIK, muscle surgery): [include date] _____

_____

Conditions that may affect ocular health (e.g. diabetes, rheumatoid arthritis, Graves' disease): _____

_____

Past infections (e.g. hepatitis, shingles, TB): _____

_____

Systemic illnesses (e.g. asthma, high blood pressure, HIV): _____

_____

Head or eye trauma (e.g. foreign body, sports injury): _____

_____

General (non-eye) surgery (include date): _____

_____

Do any medical or eye diseases run in your family? Check box for family member with that history. Leave blank if none apply. You may add "other" diseases in blank rows.

Disease	Mother	Father	Sibling	Grandparent	Other family
Glaucoma					
Macular Degeneration					
Heart disease					
Lung disease (emphysema, COPD)					
High blood pressure					
Cancer					
Diabetes					
Other (specify)					
Other (specify)					
Other (specify)					
Other (specify)					

Allergies (include type & severity of reaction): _____

_____

_____

List all your current prescription & non-prescription medications (include dosage and schedule):

Name of drug	Strength / Dosage	Schedule	Start date

Do you drink alcoholic beverages? □No

□Yes (specify): ◊ Occasionally ◊ Socially ◊ Moderately every day

◊ Heavy drinker ◊ Quit drinking

Do you use tobacco products? □No □Yes (continue): ◊Cigarettes ◊Cigars ◊Pipe ◊Chew

Specify how much/often (e.g. 1 pack/day, 3 cigars/day): _____

If employed, what is (or was, if no longer working), your occupation? _____