EyeSurgeons
OF CENTRAL NEW YORK
Lawrence C. Stewart MD
Justin M. Dexter MD
Chelsea A. Ashlaw OD
315.362.EYES (3937)
FAX: 458.7818

Date: _____ **Gender : Male Female**

Name: _____ **Date of Birth**: _____

Address: _____

Best phone number to reach you at _____

Please circle type of phone: Home Cell Business Other _____

Please give your insurance card to the receptionist at each visit to verify coverage.

Please circle an answer for all questions

Do you see another Doctor for your glasses or eye exams?If Yes-Who?

_____ or None

Do you have any allergies to any medications?

If Yes-What are they? _____ or None

Have you had any recent illness? YES NO

If yes please give a brief description. _____

Do you have any family history of eye disease such as: Glaucoma Macular Degeneration None

Do you smoke? Yes Never Quit

Please circle answer for all questions below Do you have or have you ever been treated for:

Diabetes	YES	NO
Thyroid	YES	NO
Breathing Problems	YES	NO
High Blood Pressure	YES	NO
Stroke	YES	NO
Problems with kidneys	YES	NO
Muscle or Joint Problems	YES	NO
Heart Problems	YES	NO
Cholesterol	YES	NO
Are you on any Medications	YES	NO
Did you bring a medication list with you? **PLEASE GIVE THE LIST TO THE FRONT DESK**	YES	NO (if no, please bring next time)

Race: You may choose one or more from the following list

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Hispanic or Latino ☐ Native Hawaiian or other Pacific Islander

☐ White/Caucasian ☐ Decline to answer

Preferred language:

☐ English ☐ Italian ☐ Spanish ☐ Other: _____

I would like a copy of today's visit for my personal records: (please circle) YES NO

Consent Form

I understand Eye Physicians of CNY will comply with the Notice of Privacy Practices set forth as it pertains to treatment, payment and healthcare operations as of _____ (date) until revoked by me in writing. Alternate contacts that Eye Surgeons of CNY may release my information to are listed below:

_____Relationship:_____

_____Relationship:_____

_____Relationship:_____

You may request a copy of our Privacy Practices.

_____ (signature).**(PLEASE SIGN)**

Please list your other medical doctors below:

_____

_____

_____