Date: _____ **Gender: Male Female**

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

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

Please answer all questions **Height:** _____ **Weight:** _____

Have you been diagnosed with any eye disease: _____

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 a flu vaccine this year? YES NO

Have you had a pneumonia vaccine? YES NO

Have you had any recent illness? YES NO

If yes please give a brief description. _____

Do you have any family history of eye disease: Glaucoma Macular Degeneration Retinal Detachment 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	A1C_____
Thyroid	YES	NO	
Breathing Problems	YES	NO	
High Blood Pressure	YES	NO	
Cholesterol	YES	NO	
Stroke	YES	NO	
Problems with kidneys	YES	NO	
Muscle or Joint Problems	YES	NO	
Heart Problems	YES	NO	
Are you on any Medications	YES	NO	

Did you bring a medication list with you? YES NO (if no, please bring next time)
PLEASE GIVE THE LIST TO THE FRONT DESK

Due to changes in regulations for electronic health records, we must request an update to your information. It is necessary to respond to all questions. Thank you for your cooperation.

Address: _____

Email: _____

Best phone number to reach you at: _____
Please circle type of phone: Home Cell Business Other _____

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 Surgeons 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 information to are listed below:

_____ Relationship: _____
_____ Relationship: _____
_____ Relationship: _____
_____ Relationship: _____

You may request a copy of our Privacy Practices.

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

If you are scheduled for a cataract or refractive surgery evaluation and you wear contact lenses, please remove them for 2 weeks prior to your appointment.

List your medical doctors below:

_____
_____
_____