Welcome to the office of Emily Bussey, O.D.

PATIENT INFORMATION:
Last Name:_____
First Name:_____
Middle:_____
Nickname:_____
Suffix:_____ Sex:_____ DOB:_____
Mailing Address:_____
City: _____St:_____ Zip:_____
Home:_____ Cell:_____
Work:_____ EXT:_____
Email_____
SSN:_____ Marital Status:_____
Primary Language:_____
Special Needs:_____
Race:_____ Ethnicity:_____
Occupation:_____
Employer:_____
MMN:_____ Birth State:_____
Maiden name:_____
Person Accompanying Patient:_____

Person Insured:
Name: _____
SSN:_____ DOB:_____
Medical Ins:_____ Policy#_____
Vision Ins:_____ Policy#_____

Financial Responsible Party:
Last Name:_____
First Name:_____
DOB:_____ Sex _____
Mailing Address:_____
City/St/Zip:_____
Email:_____
Home:_____ Work_____
Cell:_____
SSN:_____
Patient Relation:_____

MEDICAL INFORMATION
Do you have any problems with any of the following systems: (circle Yes or No)

Ear/Nose/Throat:
Y/N Chronic Sinusitis
Y/N Deaf
Y/N Other_____

Cardiovascular:
Y/N Heart Disease
Y/N Bypass Surgery
Y/N High Cholesterol
Y/N High Blood Pressure
Y/N Pacemaker
Y/N Stroke
Y/N Other_____

Respiratory:
Y/N Asthma
Y/N Chronic Bronchitis
Y/N COPD
Y/N Emphysema
Y/N Other_____

Allergic/Immunologic:
Y/N Seasonal Allergies
Y/N Lupus
Y/N HIV
Y/N Other_____

Gastrointestinal:
Y/N Gastric Reflux
Y/N Hernia
Y/N Ulcers
Y/N Gallbladder Disease
Y/N Other_____

Genitourinary:
Y/N Dialysis
Y/N Kidney Stones
Y/N Prostate Cancer
Y/N Kidney Disease
Y/N Other_____

Musculoskeletal:
Y/N Arthritis
Y/N Cerebral Palsy
Y/N MS
Y/N Rheumatoid Arthritis
Y/N Other_____

Integumentary:
Y/N Eczema
Y/N Skin Cancer
Y/N Other_____

Neurological:
Y/N Bell's Palsy
Y/N Epilepsy
Y/N Migraine
Y/N Seizure
Y/N Stroke
Y/N Other_____

Psychiatric:
Y/N Bipolar
Y/N Depression
Y/N Dementia
Y/N Other_____

Endocrine:
Y/N Hyperthyroidism
Y/N Hypothyroidism
Y/N Osteoporosis
Y/N Diabetes type 1 or 2, if so what year were you diagnosed_____A1C_____

Hematologic/Lymphatic:
Y/N Hemophilia
Y/N Leukemia
Y/N Other_____

Medication Allergies: Y/N List: _____
Current Medications: _____
_____
Major Operations: _____
Other Health Problems: _____
Pregnant: Y/N If so, pregnancy due date_____
SOCIAL HISTORY: Cigarettes Y/N Tobacco Y/N Alcohol Y/N Have you ever smoked? Y/N Drugs Y/N
Height: _____ Weight: _____

FAMILY HISTORY:PGM, MGM, PGF, MGF, PGP,MGP, MOTHER, FATHER AND ETC.
Glaucoma Y/N Relation: _____ Diabetes Y/N Relation: _____
Cataracts Y/N Relation: _____ Cancer Y/N Relation: _____
Macular Degeneration Y/N Relation:_____ Other Y/N Relation: _____

FOR MORE INFORMATION

If you want more information about our privacy practice ask the front desk for the copy.

Patient name_____

Signature_____Date_____

I hereby give this person(s) rights to my medical records_____

_____

Emergency Contact:_____ Phone:_____

We use a service called Demandforce to provide our patients with email and text message notifications and reminders.
Would you like to receive text message notifications & reminders from Demandforce? ___ Y ___ N
If yes, what phone number would you like them to use? _____
Can we leave a message on the cell phone number? _____Y _____N
Would you like to receive email notifications and reminders from Demandforce? ___ Y ___ N
If yes, what email address would you like them to use? _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

Who is your Primary Care Physician? _____

All about YOUR EYES:

Do you wear Contact Lenses? Y/N If so, what power/brand?_____
Would you like to wear Contact Lenses? Y/N
Are you interested in LASIK? Y/N
How many hours a day do you work on computer? _____

Do you experience:

- □ Glare at night
- □ Eye fatigue on computer
- □ Burning
- □ Itching
- □ Double vision
- □ Flashes of light
- □ Floaters
- □ Headaches
- □ Words moving on the page
- □ Tired eyes
- □ Blurred vision

List any of your eye injuries, eye surgeries or conditions of crossed eyes, lazy eye, drooping eyelid, or prominent eye:

_____

Have you been diagnosed with:

Cataracts Y/N
Glaucoma Y/N
Macular Degeneration Y/N