

OFFICE OF PECOS T. OLURIN M.D.

1403 NORTH RODNEY STREET

WILMINGTON, DE 19806

PHONE 302.654.4800 FAX 302.654.4899

OPHTHALMIC HISTORY FORM

Please cooperate with our efforts to better serve you by completing this form as accurately as possible.

Name _____ Date of Birth? _____ Age _____

List the problems that are the reason for this visit including associated non- eye related problems

Date of last eye exam: _____ by Dr _____ Do you wear glasses or contacts? YES No

How old is your current prescription? _____ What is your contact lens wear and replacement regimen? _____

Medication Please list all medications that you are on at this time.

Allergies: Please list all known and suspected allergies, especially to medicines:

Past Medical History: Please check all that apply to you or close family members:

	YES	NO	Family History		YES	NO	Family History
Eye Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis (Rheumatoid)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sarcoidosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lyme disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please describe any pertinent medical issues that you think are relevant (INCLUDE ALL PAST SURGERIES)

Do you currently smoke? YES No

Do you drink alcohol regularly YES No

Do you use now or have you used recreational drugs in the past (particularly IV drug use

YES No

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PATIENT REGISTRATION FORM

Pease print all information (complete/mark as appropriate)

Who is your primary care physician: _____ . Is the office aware of this appointment Y N

Name: _____ - _____ - _____ Sex M F Social Security # _____ - _____ - _____

Address: _____ Date of birth: _____ - _____ - _____ Age _____

City, State, Zip: _____ - _____ - _____ Marital status Single Married Divorced Widowed

Home phone: (_____) _____ Work phone: (_____) _____ ext. _____

Employer: _____ Occupation: _____

Employer address: _____

Spouse or emergency contact: _____ who referred you to our practice: _____

INSURANCE INFORMATION FILL THIS PORTION OR GIVE THE RECEPTIONIST YOUR CARD

Primary Insurance Carrier _____ Co-pay amount \$ _____

ID# _____ Group# _____

Address: _____ City, State, Zip: _____

Phone number: (_____) _____ Subscriber's name: _____

Subscriber's employer: _____

Subscriber's relationship to patient: _____

Subscriber's birth date: ____/____/____

SECONDARY INSURANCE (FILL ONLY IF YOU HAVE A SECOND INSURANCE COVERAGE)

Referral /authorization # _____ Co-pay amount \$ _____

Address: _____ City, State, Zip: _____

Phone number: _____ YES NO _____ Subscriber's name: _____

Subscriber's employer: _____ Subscriber's relationship to patient: _____

Subscriber's birth date: _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependant) have insurance coverage with _____ and assign directly to Dr Pecos T. Olurin all insurance benefits, if any, other payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

SIGNATURE OF RESPONSIBLE PARTY OR PATIENT

DATE