

**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