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Patient Name: _____ Birth Date: _____ Age: _____ Male ___ Female ___

Primary Language: _____ Race: _____ Ethnicity: Non-Hispanic Hispanic

Street _____ Town _____ State _____ Zip _____ SocSec# _____

Home Phone _____ Work Ph _____ Cell Ph _____

Pharmacy _____ Emergency Contact _____ Phone# _____

Primary Care Physician: _____ Phone# _____

Address _____ State ___ Zip _____

Insurance: Medicare Blue Shield WNY Community Blue Medicaid ID # _____
 Other _____ ID # _____

Vision Insurance: VSP Eyemed Nova Vision Other _____

We must have your insurance card so we can scan it into your chart. Medicaid, Family Health Plus, Child Health Plus, Community Card must be presented before an examination will be given.

Current Medications: please include name, strength and how often you take it. Aspirin, vitamins & herbal medications are considered medications.

Allergies to Medications or Anesthesia

SOCIAL HISTORY:

Tobacco Use: Yes No If yes, what product and how much? _____

Alcohol Use: Yes No If yes, beverage, quantity, frequency? _____

Lives: Alone With Spouse With family With friend

Student: Yes No If yes, Full Time or Part Time

FAMILY HISTORY:

Arthritis Emphysema High Blood Pressure Cancer Epilepsy Stroke Diabetes Heart
 Tuberculosis Glaucoma Cataracts Retinal Disease Macular Degeneration

