Finis C. Bailey, Jr., O.D.
Searcy, AR 72143

Insurance and Medical History

Please Complete All Of the Following:

Name: _____ Today's Date: ___/___/___

Address: _____ Email Address: _____

City: _____ State: _____ Zip Code: _____ Gender: M / F Social Secuirty #: ___/___/___

Birth Date: ___/___/___ Age: _____ Home Phone: _____ Cell Phone: _____

Texting okay: ❑ Yes ❑ No

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Race/Ethnicity: ❑ Caucasian ❑ African Amercian ❑ Hispanic ❑ American Indian ❑ Other _____

Employer: _____

Medical Doctor: _____ Eye Doctor: _____ Last Eye Exam: _____

❑ Under 18 (List Parent or Guardian): _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

INSURANCE INFORMATION (MEDICAL AND VISUAL)

VISION

Insurance Company: _____ I.D.# _____

Name of Employer: _____

Name of Primary Insured: _____ Relationship to Patient: _____

Address of Primary Insured: _____
(If different than above)

Birth Date: ___/___/___ Social Security #: ___/___/___

Phone Number: Home _____ Cell _____ Work _____

MEDICAL

Insurance Company: _____ I.D.# _____

Name of Employer: _____

Name of Primary Insured: _____ Relationship to Patient: _____

Address of Primary Insured: _____
(If different than above)

Birth Date: ___/___/___ Social Security #: ___/___/___

Phone Number: Home _____ Cell _____ Work _____

Do you have additional insurance? ❑ Yes ❑ No

Please see other side →

HEALTH HISTORY

Reason for today's exam: (REQUIRED) _____

Have you ever had eye surgery? ❑ Yes ❑ No If yes: _____

Have you ever worn contact lenses? ❑ Yes ❑ No Are you interested in wearing contact lenses at this time? ❑ Yes ❑ No

Do you have any allergy to medication? ❑ Yes ❑ No If yes, please list: _____

List any medications you take: _____

_____

List all recent major surgeries: _____

SOCIAL HISTORY

❑ I would prefer to discuss my Social History information directly with my doctor. (Check Box)

Do you drive? ❑ Yes ❑ No If yes, do you have difficulty driving? ❑ Yes ❑ No Explain: _____

_____

Do you use illegal drugs? ❑ Yes ❑ No If yes, type/amount/how long? _____

Are you pregnant? ❑ Yes ❑ No

***Smoking Status** ❑ Current everyday smoker ❑ Current some day smoker ❑ Former smoker ❑ Never a smoker

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children) for the following conditions:

DISEASE/CONDITION		RELATIONSHIP TO YOU
Glaucoma	❑ Yes ❑ No	_____
Macular Degeneration	❑ Yes ❑ No	_____
Diabetes	❑ Yes ❑ No	_____
Other	_____	

REVIEW OF SYSTEMS

Do you currently, or have you ever had problems in the following areas **(within the past 3 years)**:

Eye pain	❑ Yes ❑ No	Allergy/sinus problems	❑ Yes ❑ No
Tearing, itching, sandy feeling	❑ Yes ❑ No	Ear ache/tinnitus	❑ Yes ❑ No
Eye disease	❑ Yes ❑ No	Breathing problems	❑ Yes ❑ No
Flashes/floaters	❑ Yes ❑ No	High blood pressure	❑ Yes ❑ No
Double vision	❑ Yes ❑ No	Heart problems	❑ Yes ❑ No
Unexplained weight loss, fever, fatigue	❑ Yes ❑ No	Shortness of breath, palpitations, chest pains	❑ Yes ❑ No
Skin cancer	❑ Yes ❑ No	Stomach problems	❑ Yes ❑ No
Dementia	❑ Yes ❑ No	Kidney problems (frequency of urination)	❑ Yes ❑ No
Headache	❑ Yes ❑ No	Joint issues	❑ Yes ❑ No
Stroke	❑ Yes ❑ No	Blood disorders (anemia, bleeding, etc.)	❑ Yes ❑ No
Seizure	❑ Yes ❑ No	Anxiety	❑ Yes ❑ No
Speech problems	❑ Yes ❑ No	Depression	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Schizophrenia	❑ Yes ❑ No
Hypoglycemia	❑ Yes ❑ No	Bipolar	❑ Yes ❑ No
Thyroid abnormalities	❑ Yes ❑ No	Cancer history	❑ Yes ❑ No
Hepatitis	❑ Yes ❑ No	HIV/AIDS	❑ Yes ❑ No

Patient Name (Please print): _____

Patient or Responsible Person's Signature: _____ Today's Date: _____