SHAWN L. PALMER, M.D.

TODAY'S DATE: _____

Last Name: _____ **First Name & Initial:** _____ **Sex:** _____
Address: _____ **Apt #** _____
City _____ **State** _____ **Zip**_____ **Email** _____
Home Phone: (___) _____ **Cell:** (___) _____ **Wk:** (___) _____
Your Birthdate: _____ **Age** _____ ***Your SS #*** _____
Are you Married? Y____N_____ **Spouse's Name:** _____
Preferred Method of Communication: ***Home Phone*** _____ ***Cell Phone***_____ ***Work Phone*** ____ ***Email*** _____
Preferred Pharmacy: _____**Phone Number:** (___) _____
Family Doctor (PCP) _____**Phone:** (___) _____
Who *Referred* you to our office? _____

***Primary Medical* Insurance:** _____
Subscriber Last Name: _____ First Name: _____
Subscriber Birthdate: _____Relationship to you: _____
ID Number (from Ins. Card) _____ Group # _____

***Secondary Medical* Insurance:** _____
Subscriber Last Name: _____First Name: _____
Subscriber Birthdate: _____Relationship to you: _____
ID Number: (from Ins. Card) _____Group # _____

***Routine* Vision Insurance:** _____
Subscriber Last Name: _____First Name: _____
Subscriber Birthdate: _____Relationship to you: _____
ID Number (from Ins. Card) or SS# _____Group # _____
**Note: We will not bill routine vision visits if your vision insurance is not listed.*

RESPONSIBLE PARTY INFORMATION

Responsible Party Last Name: _____First Name:_____
Resp. Party Mailing Address: _____
Phone: Home: _____Cell: _____ Work: _____

EMERGENCY CONTACT

Name: _____Relationship: _____
Home Phone: _____Cell Phone: _____Work Phone: _____

I hereby assign all medical and/or surgical benefits, including major benefits, Medicare and other governmental sponsored programs, private insurance, and any other health plans to which I am entitled to Shawn Palmer, M.D. I further agree that my medical/medication history may be obtained electronically to facilitate my care. This assignment will remain in effect until revoked by me in writing. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits, including Medicare under Title XVIII of the Social Security Act.

Signature: _____

Name: _____ Date: _____

Please answer the following questions about your medical status and history:

1. Have you ever been treated for any medical conditions (e.g.: diabetes, high blood pressure, arthritis, etc.)?
   Yes ❑ No ❑ If YES, please explain: _____
2. Have you ever had any eye disease (e.g.: glaucoma, cataract, wandering or "lazy" eye, retinal detachment)?
   Yes ❑ No ❑ If YES, please explain: _____
3. Have you ever had any major surgery?
   Yes ❑ No ❑ If YES, please provide date and reason: _____
   _____
4. Have you ever been hospitalized (inpatient) within the last year?
   Yes ❑ No ❑ If YES, please provide date and reason: _____
   _____
5. Have you had any eye surgery?
   Yes ❑ No ❑ If YES, please list: _____
6. Please list all medications you are currently taking: _____
   _____
7. Do you have any drug or food allergies?
   Yes ❑ No ❑ If YES, please list: _____
   _____
8. Do you currently wear contact lenses or would you like to? Yes ❑ No ❑

Review of systems	Yes	No	If YES, please explain:
Do you currently have any of the following problems?			
Chronic fever, unexpected weight loss/gain, fatigue	❑	❑	_____
Ear/nose/throat problems (e.g.: hearing loss, sinus problems, sore throat)?	❑	❑	_____
Heart problems (e.g.: chest pain, irregular heart beat)?	❑	❑	_____
Urinary problems (e.g.: pain, or discomfort, blood in urine)?	❑	❑	_____
Skin problems (e.g.: rashes, excessive dryness)?	❑	❑	_____
Musculoskeletal problems (e.g.: muscle aches, joint pain, swollen joints)?	❑	❑	_____
Neurologic problems (e.g.: numbness, weakness, headaches, paralysis)?	❑	❑	_____

9. Do any medical or eye diseases run in your family (e.g.: diabetes, high blood pressure, cancer, glaucoma, macular degeneration)
   Yes ❑ No ❑ If YES, please explain: _____
   _____
10. Ethnicity: _____ Do you smoke? Y or N How much? Do you drink alcohol? Y or N

Comments: _____
_____
_____
_____
_____