Patient Pre-Visit Questionnaire

Thank you for coming today. In order to ensure that we have the most accurate information available on your medical condition, we appreciate you answering these questions about your medical history as best as you can. When you are finished, please hand this form to the technician who will further assist you.

Title (Mr., Mrs., Dr., etc.): _____ Sex: _____

First Name: _____ Last Name: _____

Reason for today's visit:

_____

_____

_____

Please list your past surgical history, including any eye surgeries and laser procedures:

_____

_____

_____

Please list any FAMILY history of any medical diseases, including eye diseases:

_____

_____

_____

Do you smoke cigarettes or cigars, chew tobacco, or vape? _____

If so, how often? _____ If not, have you ever? _____

How frequently do you consume alcoholic beverages? _____

Do you use any recreational drugs? _____ If not, have you ever? _____

If so, which drugs? _____

What is your current job occupation? _____

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Circle all that applies

Ethnicity:
Not Hispanic or Latino
Hispanic or Latino

Race:
White or Caucasian
Black or African American
Asian
Hispanic or Latino
Indian
Middle Eastern
American Indian or Alaska Native
Native Hawaiian or Other Pacific Islander
Other: _____

Preferred Language:
English
Spanish
French
Sign
Russian
Japanese
Italian
Portuguese
German
Arabic
Cantonese
Mandarin
Bengali
Hindi
Gujarati
Persian/Farsi
Haitian Creole
Vietnamese
Nepali
Deaf
Nonverbal
Other: _____

Thank you for completing this questionnaire. This questionnaire will ensure that your physician will have the most accurate information on you and your medical condition.

BURMAN & ZUCKERBROD OPHTHALMOLOGY ASSOCIATES, P.C.
PATIENT REGISTRATION AND MEDICAL HISTORY FORM
(PLEASE PRINT)

DATE_____ PATIENT NAME_____
Last Name First Name Middle Name

EMAIL ADDRESS_____ HOME PHONE_____

CELL PHONE_____ DO YOU GIVE US PERMISSION TO TEXT YOU AT THIS NUMBER? YES_____ NO_____

BIRTHDATE_____ AGE_____ SEX_____ MARITAL STATUS: SINGLE MARRIED WIDOWED SEPARATED DIVORCED

HOME ADDRESS _____ APT NO._____

CITY _____ STATE _____ ZIP CODE _____

EMPLOYER_____ OCCUPATION_____

BUSINESS ADDRESS_____ CITY_____ STATE_____

ZIP CODE_____ BUSINESS PHONE_____

SPOUSE/PARENT EMPLOYER_____ OCCUPATION_____

BUSINESS ADDRESS_____ CITY_____ STATE_____

ZIP CODE_____ BUSINESS PHONE_____

PERSON RESPONSIBLE FOR THIS ACCOUNT_____ RELATIONSHIP TO PATIENT_____

PATIENT'S SOCIAL SECURITY #_____ SPOUSE'S/PARENT'S SOCIAL SECURITY # _____

PRIMARY MEDICAL INSURANCE CARRIER_____ INSURED'S NAME_____

INSURED'S BIRTHDATE_____GROUP #_____ CONTRACT #_____

SECONDARY MEDICAL INSURANCE CARRIER_____ INSURED'S NAME_____

INSURED'S BIRTHDATE_____GROUP #_____ CONTRACT #_____

VISION/OPTICAL INSURANCE CARRIER_____

CONTRACT #_____ INSURED'S NAME_____ BIRTHDATE_____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED_____

PHONE NUMBER_____ RELATIONSHIP_____

WHOM MAY WE THANK FOR REFERRING YOU_____

I AGREE TO PAY ALL APPROVED CHARGES NOT COVERED BY MY INSURANCE CARRIER(S). THE ABOVE INFORMATION IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE, AND IS ONLY FOR USE IN MY TREATMENT, AND IN THE BILLING AND PROCESSING OF MY INSURANCE FOR BENEFITS FOR WHICH I AM ENTITLED. I WILL NOT HOLD MY DOCTOR OR ANY MEMBER OF HIS/HER STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I HAVE MADE IN THE COMPLETION OF THIS FORM.

SIGNATURE_____ DATE_____

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BURMAN & ZUCKERBROD OPHTHALMOLOGY ASSOCIATES, P.C.
PATIENT REGISTRATION AND MEDICAL HISTORY FORM
(PLEASE PRINT)

Date_____ Name_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CIRCLE ALL CONDITIONS THAT APPLY):

HIGH BLOOD PRESSURE
DIABETES
HIGH CHOLESTEROL
STROKE
ULCER
HIV/AIDS
ARTHRITIS
ARTIFICIAL HEART VALVES OR JOINTS
EPILEPSY/SEIZURES
EYE DISEASE (TYPE:_____)
LUNG DISEASE (TYPE:_____)
THYROID DISEASE (TYPE: _____)
CANCER (TYPE:_____)
BLOOD DISORDER (TYPE:_____)
DRUG OR ALCOHOL DEPENDENCY/ADDICTION (SPECIFY:_____)

LOW BLOOD PRESSURE
GENERAL ALLERGIES
SPECIAL DIET
SWOLLEN NECK GLANDS
SINUS PROBLEMS
HEADACHES
RECENT WEIGHT LOSS
CHRONIC DIARRHEA
BACK PROBLEMS
HEART PROBLEMS (TYPE:_____)
HEPATITIS, JAUNDICE, LIVER DISEASE (SPECIFY:_____)
SEXUALLY TRANSMITTED INFECTION (TYPE:_____)
NEUROLOGICAL DISORDER (TYPE:_____)
RADIATION TREATMENT (WHAT FOR:_____)
CIRCULATORY PROBLEMS (TYPE:_____)
PSYCHIATRIC DISORDER (TYPE:_____)

PLEASE LIST ANY OTHER MEDICAL CONDITIONS YOU HAVE: _____

_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: _____

_____

_____

PLEASE LIST ANY MEDICATIONS YOU ARE ALLERGIC TO: _____

PLEASE LIST ANY ANESTHETICS OR MEDICAL TREATMENTS THAT YOU HAVE RESPONDED ADVERSELY TO OR ARE ALLERGIC TO:

_____

PLEASE LIST THE NAMES AND PHONE NUMBERS OF YOUR PRIMARY CARE PHYSICIAN AND ANY OTHER PHYSICIANS YOU ARE SEEING:

_____

_____

PLEASE LIST YOUR PHARMACY NAME, PHONE NUMBER, AND ADDRESS: _____

_____

THE ABOVE INFORMATION IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE, AND IS ONLY FOR USE IN MY TREATMENT, AND IN THE BILLING AND PROCESSING OF MY INSURANCE FOR BENEFITS FOR WHICH I AM ENTITLED. I WILL NOT HOLD MY DOCTOR OR ANY MEMBER OF HIS/HER STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

SIGNATURE_____ DATE_____