AUGUSTA EYE ASSOCIATES / EYEONE
RETINA CARE OF VIRGINIA

PATIENT INFORMATION (PLEASE PRINT) **REVISED 12/11**

(NAME) LAST FIRST MI		DATE OF BIRTH	MARITAL STATUS SINGLE ☐ WIDOWED ☐ MARRIED ☐ OTHER ☐	SEX
STREET ADDRESS	CITY, STATE & ZIP CODE		HOME PHONE #	
MAILING ADDRESS	CITY, STATE & ZIP CODE		CELL PHONE #	
SOCIAL SECURITY #	☐ DISABLED ☐ RETIRED	EMPLOYER PHONE #		
RACE ☐ AFRICAN AMERICAN ☐ CAUCASIAN ☐ HISPANIC ☐ KOREAN ☐ MULTIRACIAL ☐ OTHER	LANGUAGE ☐ ENGLISH ☐ SPANISH ☐ MUTE/DEAF ☐ OTHER		ETHNICITY ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO ☐ OTHER	
EMAIL		PRIMARY CARE PRACTITIONER		

EMERGENCY CONTACT

NAME	RELATIONSHIP	PHONE #

INSURANCE INFORMATION

CARRIER	ID #

IF POLICY HOLDER IS OTHER THAN PATIENT, PLEASE COMPLETE

POLICY HOLDER ____ MALE ☐ FEMALE ☐
SOCIAL SECURITY # ____
DATE OF BIRTH ___________________
EMPLOYER ____

IF PATIENT IS A MINOR (GUARANTOR INFORMATION)

LAST FIRST MI	DATE OF BIRTH	SOCIAL SECURITY #
STREET ADDRESS, CITY, STATE, & ZIP CODE		HOME PHONE #
EMPLOYER		WORK PHONE #

EyeOne / RetinaCare of Virginia

Patient Name ________________________ Date of Birth____/ ____ /____Date ________

Clinical staff will assist you with gray areas.

Review of Systems – Do you currently have any of these conditions?

__Yes __No Allergies
__Yes __No Chest pressure, pain /discomfort, irregular heartbeat
__Yes __No Fever or Night Sweats
__Yes __No Cold or Heat intolerance, excessive thirst or hunger
__Yes __No Hearing Loss
__Yes __No Constipation, Diarrhea or Vomiting
__Yes __No Painful / Excessive Urination, Blood in Urine
__Yes __No Bruising or Easy Bleeding
__Yes __No Rash
__Yes __No Arthritis, joint pain or muscle weakness
__Yes __No Dizziness, headache
__Yes __No Emotional Change
__Yes __No Cough or wheezing

Medications (if unable to complete staff will assist you)
(Attach list or list any medications that you now take.)

____
____
____
____
____
____
____

List any drug allergies Reaction________

None ☐ **Please list Example: rash, swelling, etc.**

____
____
____
____

Blood Sugar (If known)

Blood Sugar ________ A1C ______________
Date Taken __________

Past Eye History – Have you ever had any of these eye conditions?

__Yes __No Cataract
__Yes __No Cornea/Conjunctiva problem
__Yes __No Glaucoma
__Yes __No Refractive Surgery/LASIK
__Yes __No Neurological eye problem
__Yes __No Plastic Surgery around eyes
__Yes __No Retina __Tears __Detachment
__Yes __No Eye turning In or Out

Medical History

List any medical conditions for which you have ever been treated:

____
____
____
____
____
____
____
____
____
____
____

Surgical History

Provide date and reason for any surgery:

____
____
____
____
____

Family History Relationship

Do any of these conditions run in your family?

__Yes __No Blindness ______________
__Yes __No Cataracts ______________
__Yes __No Glaucoma ______________
__Yes __No Macular Degeneration ______________
__Yes __No Retinal Disorders ______________
__Yes __No High Blood Pressure ______________
__Yes __No Diabetes ______________
__Yes __No Heart Disease ______________

Social History

__Yes __No __Formerly Used Tobacco
__ Current every day smoker
__ Former smoker
__ Current some day smoker
__ Never a smoker

___Yes __No __Formerly Used Alcohol

Tech Review _______Date_______ Tech Review _______Date_______

Additional Insurance Information

Insurance Name ______________________________

Insurance Phone # ______________________________

Member ID # ______________________________

Name of Vision Coverage (if known) ______________________________

Group # ______________________________

Subscriber Name ______________________________

Subscriber SSN ______________________________

Subscriber DOB ______________________________