

**VISION CARE OF TULSA**

Date \_\_\_\_\_

**PATIENT INFORMATION**

Name		Birthdate	Sex M F	
Address		City	State	Zip
Social Security No.	Marital Status	CELL PHONE	Home Phone	
Occupation		Employer	Work Phone	
Spouse's Name	SOCIAL SECURITY #	Employer	Work Phone	
Names of Children Living at Home				
Parents' or Guardians' Names		Employer(s)	Work Phone(s)	
Parents' or Guardians' Address (if different than above)			Home Phone	
~~~~~ <b>PRIMARY INSURANCE</b> No need to complete if able to supply receptionist with insurance card. Is primary insurance Medicare? Yes No				
Insured's Name	Insured's I.D. Number	Insured's Date of Birth		
Relation to Insured	Insurance Company	Group Number	Policy Number	
<b>SECONDARY INSURANCE</b> Include supplemental Medicare insurance				
Insured's Name	Insured's I.D. Number	Insured's Date of Birth		
Relation to Insured	Insurance Company	Group Number	Policy Number	

**ASSIGNMENT OF BENEFITS**

I hereby request that payment of Medicare or health insurance benefits be made on my behalf to either myself, or directly to Dr. Steven Cartmell for any services furnished me by him. I authorize the release of medical information about me needed to determine these benefits. A photocopy of this assignment is considered as valid as the original. This authorization may be revoked by me at any time.

\_\_\_\_\_  
Patient, Parent, or Guardian

\_\_\_\_\_  
Date

**STEVEN CARTMELL, O.D.  
MEDICAL PROFILE**

NAME \_\_\_\_\_ DATE \_\_\_\_\_

DATE OF LAST EXAM \_\_\_\_\_ HOW DID YOU HEAR ABOUT US? \_\_\_\_\_

REASON FOR APPOINTMENT: (check all that apply)

- CHECK UP
- CONTACTS \_\_\_\_\_ TINTED
- GLASSES
- OTHER \_\_\_\_\_

- BLURRED VISION/DISTANCE
- BLURRED VISION/NEAR
- HEADACHES

OCCUPATION \_\_\_\_\_ HOBBIES \_\_\_\_\_

SPORTS-OUTDOOR \_\_\_\_\_ INDOOR \_\_\_\_\_

FAMILY DOCTOR NAME \_\_\_\_\_ DATE OF LAST TETANUS SHOT \_\_\_\_\_

ANY NIGHT DRIVING? \_\_\_\_\_ COMPUTER USE? \_\_\_\_\_  
DO YOU USE TOBACCO? \_\_\_\_\_ ALCOHOL? \_\_\_\_\_ OTHER SUBSTANCES? \_\_\_\_\_

DO YOU NOTICE: (Mark all that apply)

- ITCHING
- BURNING
- EYE PAIN
- DRYNESS
- CRUSTING
- FLASHES
- FLOATERS OR SPOTS
- REDNESS
- DOUBLE VISION
- VARIABLE VISION
- TURNED EYE
- WATERY EYES
- CHANGE IN APPEARANCE OF EYE OR EYELID
- HEADACHES
- TEMPORARY VISION LOSS
- EXTREME LIGHT SENSITIVITY

DO ANY OF THE FOLLOWING APPLY TO YOU: (Mark all that apply)

- DIABETES
- HIGH BLOOD PRESSURE
- HEART PROBLEMS
- ALLERGIES
- EXPERIENCE FEVER BLISTERS OR COLD SORES
- TUMORS OR GROWTHS
- SEXUALLY TRANSMITTED DISEASE
- GLAUCOMA
- EYE SURGERY
- LAZY EYE
- TURNED EYE
- COLOR BLINDNESS
- EYE DISEASE
- EYE OR HEAD INJURIES
- DRUG SENSITIVITIES
- ARE YOU PREGNANT OR NURSING?
- DO YOU HAVE OTHER HEALTH PROBLEMS(Explain) \_\_\_\_\_

HAVE YOU WORN CONTACTS?  
 DO YOU WEAR CONTACTS NOW?  
IF SO, HOW LONG? \_\_\_\_\_  
 DO YOU SLEEP IN YOUR LENSES?

LIST ALL CURRENT MEDICATIONS, INCLUDING OVER-THE-COUNTER, VITAMINS AND EYE DROPS.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HAS ANYONE IN YOUR FAMILY HAD:

- EYE DISEASE (Explain) \_\_\_\_\_
- BLINDNESS (Explain) \_\_\_\_\_
- COLOR BLINDNESS \_\_\_\_\_
- GLAUCOMA (Relation) \_\_\_\_\_
- MACULAR DEGENERATION (Relation) \_\_\_\_\_
- RETINAL DETACHMENT (Relation) \_\_\_\_\_

- EAR \_\_\_\_\_
- NOSE \_\_\_\_\_
- MOUTH \_\_\_\_\_
- THROAT \_\_\_\_\_
- NECK \_\_\_\_\_
- THYROID \_\_\_\_\_
- LUNG \_\_\_\_\_
- STOMACH OR GI TRACT \_\_\_\_\_
- GENITOURINARY \_\_\_\_\_
- MUSCULOSKELETAL \_\_\_\_\_
- NEUROLOGICAL \_\_\_\_\_
- PSYCHIATRC \_\_\_\_\_
- LEARNING DISABILITY \_\_\_\_\_
- ENDOCRINE GLANDS \_\_\_\_\_
- BLOOD/LYMPH \_\_\_\_\_
- ALLERGIC/IMMUNOLOGIC \_\_\_\_\_
- SKIN \_\_\_\_\_