Edward Zikoski, O.D., FAAO

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Patient Information

Please Print

Date ____________________ Email Address ________________________________

Patient's Name ________________________________ Sex ______________

Street Address ____

City ________________________ State ______________ Zip ______________

Phone Number (Home) ________________________(Other) ________________________

Date of Birth ______________ Age ______________ Social Security No. ______________

Guarantor's Information

(Policy Holder of the Insurance or Person Responsible for bill)

Name ________________________________ Spouse's First Name ______________________

Date of Birth ____________________________ Social Security No. ______________________

Address (if different than patient) ____

Phone Number (Home) ________________________(Other) ________________________

Employer ______________________ Address ________________________________

Work Phone ____________________________

Referred By ______________________ Pediatrician / Family Doctor ______________________

Insurance Information

Insurance Company ________________________________ I.D. # ______________________

Secondary Insurance ______________________________ I.D. # ______________________

Pediatric Patients Birth History

Full Term __________ Premature __________ Birth Weight __________

Complications ____

Father's Name ______________________ Father's Occupation ______________________

Employer's Name & Address ____

Mother's Name ______________________ Mother's Occupation ______________________

Employer's Name & Address ____

Patient's or Authorized Person's Signature

I authorize any holder of medical information about me to release to the HCFA/Insurance Company's and it's agents any information needed to determine these benefits or the benefits payable for related services.

Signed ____ Date ______________________

Insured or Authorized Person's Signature

I request that payment of authorized Medicare/Insurance Benefits may be made either to me or on my behalf to my doctor/provider for any services furnished by the physician/provider.

Signed ____ Date ______________________

Why Are You Here?

Right Eye	Left Eye	Symptom	How Long?
		Dry eye feeling	
		Discharge from the eyes	
		Redness	
		Itching	
		Foreign body sensation	
		Sandy Feeling	
		Grittiness	
		Burning	
		Constant tearing and wetness	
		How many times daily	
		Sinus trouble	
		Headache	
		Hay fever	
		Nasal congestion	
		Ear trouble	
		Head allergy	
		Post nasal drip	
		Bronchitis-chronic	
		Cough-chronic	

Further comments on above questions: ____

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Have you ever had any of the following?

Eye injury Yes No

Eye surgery Yes No

Eye condition Yes No

Are you taking any medication at the present time? Yes No

If YES, for what condition ________________________________

Are you allergic to any medication? Yes No

Do you wear glasses? Yes No

How long have you had your present glasses? ______________________

Have you or any family (blood relative) member had any of the following medical problems?

If Yes, state who:

Glaucoma	Yes	No	____________
Used eye drops	Yes	No	____________
Cataracts	Yes	No	____________
Diabetes	Yes	No	____________
Tuberculosis	Yes	No	____________
Thyroid disorder	Yes	No	____________
High blood pressure	Yes	No	____________
Asthma	Yes	No	____________
Heart disease	Yes	No	____________