AUKER EYE INSTITUTE
2324 Santa Rita Road, Suite 7
Pleasanton, CA 94566
TODD A AUKER, M.D.

CONFIDENTIAL PATIENT INFORMATION

Last Name _____ First Name _____ M.I. _____ Age _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Circle one: Male Female Social Security # _____

Home Phone # (___)_____ Cell #. (___)_____ Work # (___)_____ Ext. _____ Student? Y N

Marital Status: Circle One: M W D S Occupation _____ Employer _____

Whom shall we thank for your referral? _____ Optometrist _____

E-Mail Address _____

RESPONSIBLE PARTY INFORMATION

Last Name _____ First Name _____ M.I. _____ Age _____

Address _____ City _____ State_____ Zip _____

Date of Birth _____ Circle one: Male Female Social Security # _____

Home Phone # (___)_____ Patient's relationship to responsible party _____

Employer's Name _____ Employer's Phone # (___)_____

Emergency contact person not living with you _____ Phone # (___)_____

PRIMARY INSURANCE INFORMATION Do you have a copay? _____ Copay amount _____

Insurance Carrier _____ Claims address _____

I.D. # _____ Effective Date _____ Phone # (___)_____

Name of Insured _____ Circle one: Male Female Date of Birth _____

Group Name _____ Group # _____ Medical Group _____

SECONDARY INSURANCE INFORMATION Do you have a copay? _____ Copay amount _____

Insurance Carrier _____ Claims address _____

I.D. # _____ Effective Date _____ Phone # (___)_____

Name of Insured _____ Circle one: Male Female Date of Birth _____

Group Name _____ Group # _____ Medical Group _____

Vision Insurance _____ I.D. # _____ Insured SS # _____

Primary Care Physician _____ Phone # (___)_____

AUTHORIZATION: I hereby authorize the physicians indicated above to furnish information to insurance carriers concerning this illness/accident, and I hereby irrevocably authorize the doctor all payment for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.

X _____ Date _____

Updates: Verified Date:

_____ _____

_____ _____

PLEASE SEE BACKSIDE

Patient Name _____ Age _____ Date _____

Primary Care Physician _____ Phone # (___) _____

ALLERGIES TO MEDICATIONS (Please list below)

Check here if you have no known drug allergies ☐

_____ _____

_____ _____

Current Medications (Including any EYE DROPS)

_____ For _____

_____ For _____

_____ For _____

_____ For _____

_____ For _____

_____ For _____

Have you ever had any of the following conditions?

☐ Sensitivity to light ☐ Floaters or spots

☐ Double vision ☐ Poor distance vision

☐ Eye infections ☐ Poor near vision

☐ Eyes burn, itch, or water ☐ Eye strain

☐ Turned or lazy eye ☐ Macular degeneration

☐ Retina Detachments ☐ Cataracts

☐ Eye Pain ☐ Drooping eyelid

☐ Mucous Discharge ☐ Loss of vision

☐ Blurred vision ☐ Loss of side vision

☐ Headaches

Previous Eye Surgeries? No Yes (if yes please list)

_____ Year _____

_____ Year _____

_____ Year _____

_____ Year _____

Previous other Surgeries or Hospitalization: No Yes

(if Yes please list)

_____ Year _____

_____ Year _____

_____ Year _____

_____ Year _____

Family History

Has anyone in your immediate family been diagnosed with

M=Mother F=Father S=Sibling GP=grandparent

Heart Disease: No Yes Family Member: M F S GP

Diabetes: No Yes Family Member: M F S GP

Glaucoma: No Yes Family Member: M F S GP

Cataracts: No Yes Family Member: M F S GP

Patient History:

Have you ever been diagnosed with:	Yes	No
Arthritis	☐	☐
Diabetes Under Control Y N	☐	☐
Heart Trouble	☐	☐
High Blood Pressure	☐	☐
Stroke (when _____)	☐	☐
Epilepsy	☐	☐
Asthma/Emphysema	☐	☐
Cancer (type _____)	☐	☐
Hepatitis	☐	☐
HIV	☐	☐
Tuberculosis	☐	☐

Social History

Do you Smoke? No Yes Packs per day _____

Do you Drink? No Yes

Daily _____ Weekly _____ Socially _____

Are you in a high-risk group for AIDS? No Yes

Other Medical Problems? No Yes (if Yes please list)

_____

_____

_____

What Pharmacy do you use? _____

City: _____ Phone # (___) _____

FOR OFFICE USE ONLY

Medical Update _____/_____/_____

_____/_____/_____

The above information is complete and warranted to be true, and will not be released without my written permission

Date: _____ Signature: _____