SEEMA J. ICE, M.D. / BERNARD D. PERLA, M.D.

OPHTHALMOLOGY & OPHTHALMIC SURGERY

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PAINESVILLE, OHIO 44077
(440)354-6900

PATIENT INFORMATION FORM

Welcome to our office. Please complete this form and return it to the receptionist so your chart can be prepared

DATE _____

PATIENT'S NAME	SOCIAL SECURITY #	SEX M F	AGE	BIRTHDATE / /
ADDRESS STREET / CITY / STATE / ZIP			PHONE #	
OCCUPATION	EMPLOYER	EMPLOYER ADDRESS		
NAME OF SPOUSE	EMPLOYER			
IF UNDER 18 YEARS OF AGE OR A STUDENT — NAME OF FATHER		EMPLOYER		
NAME OF MOTHER		EMPLOYER		

MAY WE LEAVE A MESSAGE ON YOUR ANSWERING MACHINE? ☐ YES ☐ NO

MAY WE LEAVE A MESSAGE WITH A FAMILY MEMBER? ☐ YES ☐ NO

NAME OF INSURANCE & POLICY NUMBER _____

AUTHORIZATION FOR MEDICARE OR OTHER INSURANCE CARRIER PAYMENTS TO ICE OPHTHALMOLOGY, INC.

I AUTHORIZE THE USE OF THIS FORM ON ALL MY INSURANCE SUBMISSIONS AND RELEASE OF INFORMATION TO ALL MY INSURANCE COMPANIES. I AUTHORIZE MY DOCTOR TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT FROM MY INSURANCE COMPANY AND DIRECT PAYMENT TO MY DOCTOR

SIGNATURE _____ DATE / /

PAYMENT OF FEES IS THE RESPONSIBILITY OF PATIENT USUALLY DUE AT THE TIME OF SERVICE, UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE

MEDICAL INFORMATION

WHO REFERRED YOU TO OUR OFFICE?	FAMILY DOCTOR'S NAME	
ARE YOU HERE BECAUSE OF AN EYE INJURY? ☐ YES ☐ NO IF SO, DID IT OCCUR AT WORK? ☐ YES ☐ NO	DATE OF ONSET / /	ARE YOU HERE FOR A REGULAR ROUTINE CHECK-UP? ☐ YES ☐ NO
IF YOU ARE HAVING PROBLEMS WITH YOUR EYE(S) PLEASE DESCRIBE:		
DO YOU WEAR GLASSES? ☐ YES ☐ NO DO YOU WEAR CONTACT LENSES? ☐ YES ☐ NO	DATE OF YOUR LAST EYE EXAM? / /	DO YOU USE EYE DROPS ROUTINELY? ☐ YES ☐ NO
MEDICATIONS PLEASE LIST NAMES:		
ARE YOU ALLERGIC TO ANY MEDICINE? ☐ YES ☐ NO IF SO, PLEASE LIST		DO YOU SMOKE? ☐ YES ☐ NO

DO YOU HAVE (OR DID YOU EVER HAVE): (CHECK ALL THAT APPLY)

YES	NO		YES	NO	
☐	☐	DIABETES	☐	☐	CATARACT
☐	☐	ARTHRITIS	☐	☐	GLAUCOMA
☐	☐	THYROID DISEASE	☐	☐	MACULAR DEGENERATION
☐	☐	SKIN DISEASE	☐	☐	LAZY EYE
☐	☐	HEART ATTACK	☐	☐	CROSSED EYE
☐	☐	AIDS/HIV	☐	☐	COLOR BLINDNESS
☐	☐	STROKE	☐	☐	EYE SURGERY
☐	☐	HEPATITIS	☐	☐	EYE INJURY
☐	☐	HIGH BLOOD PRESSURE			

OTHER ILLNESSES? _____

DID ANYONE IN YOUR FAMILY HAVE:

YES	NO	
☐	☐	CATARACT
☐	☐	GLAUCOMA
☐	☐	MACULAR DEGENERATION
☐	☐	LAZY EYE
☐	☐	CROSSED EYE
☐	☐	COLOR BLINDNESS
☐	☐	EYE SURGERY
☐	☐	DIABETES
☐	☐	HIGH BLOOD PRESSURE

OTHER ILLNESSES? _____