☐ EHR only

Person # _____

Gailey Eye Clinic

PATIENT HISTORY QUESTIONNAIRE

Patient Name _____
Last First Middle Initial

Social Security Number _____

Birth date _____ _____ _____ Age _____
Month Day Year

(Circle One)
Male Female

Address _____
Number Street

_____
City State Zip Code

Phone (_____) _____ (Home)

(_____) _____ (Work)

E-mail _____

Marital Status M _____ S _____ D _____ W_____

Ethnicity Hispanic_____ Non-Hispanic_____ Other_____

Race (Select One)
White_____ Black or African American _____ Asian_____
Native American/Eskimo_____ Multiracial_____
Native Hawaiian or Other Pacific Islander _____ Other_____

Language _____

Patient Occupation / Student _____

Employer Name / Year in School _____

Name of Emergency Contact _____

Phone # of Emergency Contact (_____) _____

How did you hear about us? _____

LASIK is a procedure that reduces or eliminates the need for eye glasses or contacts. Have you ever considered LASIK before?
Yes _____ No _____

Family Physician _____

Were you referred to this clinic by another doctor?
Yes _____ No _____

If yes, do you wish the doctor to have a report?
Yes _____ No _____

Name of referring doctor _____

Address _____

PRIMARY INSURANCE _____

Insurance Address _____

Policy Number _____

Group Number _____

Subscriber's Name _____

Subscriber's Date of Birth _____

Subscriber's Social Security Number _____

SECONDARY INSURANCE _____

Insurance Address _____

Policy Number _____

Group Number _____

Subscriber's Name _____

Subscriber's Date of Birth _____

Subscriber's Social Security Number _____