952 Troy-Schenectady Road	**Dr. Elisa Perreault**	**99 Pine Street**
Latham, NY	**Dr. Sharon Hunt-Moriarty**	**Albany, NY**
785-1199	**Dr. Michelle Hall**	**463-1707**

Patient Name:______________________________________ **Today's Date:**_____________________
Date of Birth: _________________________ **Social Security Number:** _________________________
Marital Status:________________________
Daytime Phone:(_____)_______________**Cell Phone:**(_____)_______________**May we text you?** **Yes** **No**
Email Address: ____

Who can we thank for referring you to us today? _______________________________________

Race:
African American/Black
Asian
Caucasian/White
Hispanic
Native American/Native Alaskan
Native Hawaiian/Other Pacific Island

Ethnicity:
Hispanic/Latino
Native Hawaiian/Other Pacific Island
Not Hispanic/Latino

Preferred Language:
English Other:_________________

Employer:___________________________________ **Occupation:**________________________
Primary Care Physician Name, Address, Phone Number:
____
____Date last seen:___________________________

Are you currently pregnant? Yes No Expected Due Date? ___________ Are you currently breastfeeding? Yes No

Vision Insurance: Company ____________________ ID ___________________________
Primary Health Insurance Information:
Insurance Company _______________ Insured Name: _______________________Date of Birth: _________________
Insurance ID Number _________________________Relationship to Insured: __________________________________

Secondary Health Insurance Information:
Insurance Company _______________ Insured Name: _______________________Date of Birth: _________________
Insurance ID Number _________________________Relationship to Insured: __________________________________

Signature on File

I authorize use of this form on ***all*** *insurance. I authorize release of information to all my* ***Insurance Companies.*** *I authorize my doctor to act as* ***my*** *agent in helping me to obtain payment from my Insurance Companies. I authorize payment direct to my doctor. I permit a copy of this authorization to be used in place of the original.*

X____ Date:_____________________

Please Circle any additional testing you would like to receive today:
OPTOMAP ($30) OCT ($10) VISUAL FIELD ($10)

Would you like to receive dilation today? Yes Will return at another time

Do you currently wear contacts? Yes No Are you interested in Contacts? Yes No

By signing below, you acknowledge that you have received and read a copy of our Office Policies, including the Privacy Policy, HIPAA acknowledgement, and Additional Testing Policy. You are acknowledging your understanding herein that it is your sole responsibility to pay any additional fees for services or products not covered by your insurance company.

X____ Date: _________________
Signature, Patient or Parent/Guardian (if patient is under 18)

PATIENT HEALTH HISTORY

Patient Name: ________________________________ **DOB** ______________________

Medical/Family History

Please list ALL current medications (prescription, over the counter, vitamins/supplements)
____

Allergies to medication or eye drops? Yes No If yes, please list____________________________________

List all major surgery, including eye surgery, and date of surgery:
____

Do you drink alcohol? Yes No Do you smoke cigarettes? Yes No
Do you currently use recreational drugs? Yes No

Please indicate if any of these diseases/ conditions apply to you or a blood relative

Disease/Condition	Yourself		Blood Relative		Relationship
Cataract	Y	N	Y	N	____________________
Eye Turn	Y	N	Y	N	____________________
Glaucoma	Y	N	Y	N	____________________
Macular Degeneration	Y	N	Y	N	____________________
Retinal Detachment	Y	N	Y	N	____________________
Blindness	Y	N	Y	N	____________________
Diabetes	Y	N	Y	N	____________________
Hypertension	Y	N	Y	N	____________________
Other ____________________	Y	N	Y	N	____________________

Please indicate below if you have ever had a problem with the following conditions

Allergic/immunologic	Ear, Nose, Throat	Gastrointestinal	Skin/ Integumentary
none	none	none	none
Lupus	Sinusitis	Crohn's Disease	Eczema
Rheumatoid arthritis	Upper Respiratory Infection	Colitis	Rosacea
Environmental	other	other	other
Seasonal			
Other (i.e latex)			

Cardiovascular	Endocrine/Glands	Respiratory	Muscle/Skeletal
None	none	none	none
High blood pressure	Diabetes	Asthma	Arthritis
Heart disease	Hormone dysfunction	Bronchitis	Fibromyalgia
Stroke	Thyroid dysfunction	Emphysema	Ankylosing spondylitis
Vascular disease	other	other	other
High cholesterol			

Hematologic/Lymphatic	Neurological	Psychiatric	Genital/Urinary
None	none	none	none
Anemia	Multiple Sclerosis	Depression	Urinary tract infection
Leukemia	Epilepsy	Bi-polar	HIV positive
Other	other	other	other

Please sign to acknowledge that all above information is current and correct

X____ Date:__________________________