PATIENT / ACCOUNT INFORMATION
THE TOLEDO CLINIC

DATE	CHART NUMBER

DOCTOR	PRIMARY CARE PHYSICIAN & CITY

A PATIENT INFORMATION

NAME LAST	FIRST	INITIAL	DATE OF BIRTH	AGE	SEX ☐ M ☐ F	SOCIAL SECURITY NUMBER

MAIDEN NAME	ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	CELLULAR PHONE	E-MAIL ADDRESS	MARITAL STATUS	SPOUSES NAME

EMERGENCY CONTACT	RELATIONSHIP	PHONE EXT	CELLULAR PHONE

ADDITIONAL CONTACT	RELATIONSHIP	PHONE EXT.	CELLULAR PHONE

PREFERRED METHOD OF CONTACT
- ☐ CELLPHONE
- ☐ HOME PHONE
- ☐ E-MAIL
- ☐ TEXT

RACE
- ☐ AMERICAN INDIAN OR ALASKA NATIVE
- ☐ ASIAN
- ☐ BLACK OR AFRICAN AMERICAN
- ☐ HAWAIIAN OR PACIFIC ISLANDER
- ☐ WHITE
- ☐ OTHER
- ☐ UNKNOWN
- ☐ DECLINED

ETHNICITY
- ☐ HISPANIC OR LATINO
- ☐ NOT HISPANIC OR LATINO
- ☐ UNKNOWN
- ☐ DECLINED

LANGUAGE
- ☐ ARABIC
- ☐ CHINESE
- ☐ ENGLISH
- ☐ FRENCH
- ☐ JAPANESE
- ☐ SPANISH
- ☐ VIETNAMESE
- ☐ UNKNOWN
- ☐ DECLINED

B PERSON RESPONSIBLE FOR PAYMENT - IF PATIENT IS A CHILD THE PERSON WHO HAS CUSTODY

NAME LAST	FIRST	INITIAL	DATE OF BIRTH	SEX ☐ M ☐ F	SOCIAL SECURITY NUMBER

ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	CELLULAR PHONE	E-MAIL ADDRESS

C INSURANCE INFORMATION

INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER

ADDRESS	CITY	STATE	ZIP CODE

NAME OF POLICY HOLDER	DOB OF POLICY HOLDER	EFFECTIVE DATE	RELATIONSHIP TO PATIENT

INSURANCE EMPLOYER NAME	PCP CO-PAYMENT AMT	SPECIALIST CO-PAY AMT

INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER

ADDRESS	CITY	STATE	ZIP CODE

NAME OF POLICY HOLDER	DOB OF POLICY HOLDER	EFFECTIVE DATE	RELATIONSHIP TO PATIENT

INSURANCE EMPLOYER NAME	PCP CO-PAYMENT AMT	SPECIALIST CO-PAY AMT

I CONFIRM THAT THE ABOVE INFORMATION IS CORRECT:

SIGNATURE _____ DATE _____

VISION ASSOCIATES MEDICAL HISTORY **Please Print**

Name _____ Birth date _____ Appt Date____-____-____

Family Doctor _____ Vision Associates Doctor @ next appt_____

Please circle previous diagnoses regarding **the patient's** eye health:

Cataracts Glaucoma Dry eyes Macular degeneration Lazy eye (Right or Left?)

Please list past eye surgeries including the procedure, date of surgery and surgeon.

_____

_____

Please circle all conditions that apply to the patient's immediate **family** members (mom, dad, siblings, children):

Glaucoma Macular Degeneration

Diabetes Hypertension Heart disease Thyroid MS

No family history known Adopted

Please circle all that apply to the **patient**:

Type 1 Diabetes	**Type 2 Diabetes**	**Thyroid disease**	
Hypertension	**CHF/heart failure**	**MI/heart attack**	
COPD	Asthma	Emphysema	Sleep apnea
MS	Crohn's disease	Reflux	
Alzheimer's	Dementia	Migraine	
Myasthenia gravis	Parkinson's	Stroke when? _____	TIA when? _____
Renal failure	Dialysis	Kidney stones	
Arthritis	Fibromyalgia	Lupus	Rheumatoid arthritis
Acne Rosacea	Eczema		

Other: _____

Do you smoke? Yes No

If yes, do you smoke everyday? Yes No Packs per day? _____

If no, are you a former smoker? Yes No Year quit? _____

Do you drink alcohol? Yes No

Occupation: _____

Marital status: Single Married Divorced Widowed

Please turn over

Please list your allergies:

Allergen	Reaction

Please list your medications:

Please list your pharmacy & location _____ @_____

Please document how you are feeling **today**. Circle all that apply:

Constitutional:	fatigue	fever	weight loss	chills	sweats	sleep disturbance
ENT:	earache	nasal congestion			sore throat	sinus pain
Cardiovascular:	chest pain	palpitations	leg edema		increased heart rate	
	decreased heart rate					
Respiratory:	short of breath	wheezing	coughing		difficulty breathing	
Gastrointestinal:	diarrhea	nausea	vomiting		indigestion	constipation
Integumentary:	rosacea	rash	change in hair		change in nails	
Musculoskeletal:	joint pain	muscle pain	back pain			
Neurological:	slurred speech	memory loss	dizziness		weakness	
Hematologic:	abnormal bleeding		enlarged lymph nodes			swollen glands
Immunologic:	food allergies	seasonal allergies			immune disorders	
Endocrine:	temperature intolerance		excess thirst			
Psychiatric:	depression	anxiety				

Current Height: _____ Current Weight:_____

ACKNOWLEDGMENT OF RECEIPT OF TOLEDO CLINIC'S NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received Toledo Clinic's Notice of Privacy Practices effective April 14, 2003, rev 03/31/2013

Staff Use Only

PATIENT CHART NUMBER_____

_____
Signature of Patient

_____
Printed Name of Patient

_____
Date of Birth

_____
Signature of Parent/Guardian of Minor

_____
Date

Staff use only

Good Faith Effort to Obtain Acknowledgment

The above named patient refused to sign the acknowledgment after being requested to do so.

_____
Staff Member Signature

Date:_____

PERSONS THAT ARE ALLOWED TO GIVE/RECEIVE MY PRIVATE HEALTH INFORMATION

METHOD OF ALLOWED RELEASE: _____ VERBAL _____WRITTEN

Name	Relationship	Phone#
Name	Relationship	Phone#
Name	Relationship	Phone#