

JAMES PODSCHUN, O.D., P.A.

"Jim" (Pa.choon)

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Winter Park, Florida 32792

Welcome to our office. Please take a few moments to fill out the information below for entry into your eye health file. This information is strictly confidential and will be used to help us provide you with comprehensive eye care.

PLEASE PRINT

Date: _____
Patient's Name: _____ Age: _____ Sex: M F
Date of Birth: _____ Responsible party if minor: _____ Race: _____
Address: _____
Street Apt# City State Zip
PHONE: (Home) _____ (Work) _____ (Cell) _____ E-mail _____
Employer: _____ Occupation: _____ If student: School _____ Grade: _____

IF THIS IS YOUR FIRST VISIT, HOW DID YOU HEAR OF US? (Please Circle)

Family Friend Doctor Yellow Pages Postcard Letter Brochure Passing By Insurance List Other: _____
If Referred, Whom may we thank for the referral? _____

HEALTH & VISION PROFILE

Do you work on a computer regularly? Yes No Does this computer work affect your vision? Yes No
Hobbies/Sports: _____ Does your vision affect performing this sport/hobby? Yes No
Unusual Visual Demands: _____ Date of Last Eye Exam: _____
Family Physician: _____ Phone: _____ Last Medical Exam: _____
List any drugs or medications you are taking: _____
List any drug allergies: _____ Environmental allergies: _____

PLEASE CHECK THE FOLLOWING THAT APPLY

	SELF		BLOOD RELATIVE				
	Yes	No	Yes	No			
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/> Redness	<input type="checkbox"/> Eyes Water
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Spots	<input type="checkbox"/> Styes	<input type="checkbox"/> Eyes Burn
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Blur at Night
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Light Sensitive	<input type="checkbox"/> Blur at distance with glasses	
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Eyes Tire Easily	<input type="checkbox"/> Blur at distance w/o glasses	
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Blur at near with glasses		
Cross Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Blur at near w/o glasses		
Major Surgery/Illness? _____					<input type="checkbox"/> Previous Eye Surgery (type) _____		

Are you interested in contact lenses today? Yes No
Are you presently wearing contact lenses? Yes No (Type, disposable, soft, gas permeable, other _____)
Have you worn contact lenses in the past? Yes No

PAYMENT & INSURANCE INFORMATION

METHOD OF PAYMENT (Please Circle) Cash Check Visa MasterCard Discover Insurance Flex Plan

Health Insurance: _____
(Medical) (Vision) (Social Security Number)

I understand that I am responsible for my bill. I authorize the release of this information to all my insurance carriers, and for the doctor to act as my agent in helping me obtain payment from my insurance carriers. I authorize payment directly to my doctor, and permit a copy of this authorization to be used in place of the original. I understand that I am responsible for any copayments, deductible, & non-covered services.

Signature (Guardian) Date