EDMOND REGIONAL EYE ASSOCIATES

Robert D. Gourley, M.D.
M. Andrew Hogue, M.D.

Date__________________

Name: ____

Address: ____

City: ____ State:___________ Zip:______________

Date of Birth: ______________ Age: ______ Social Security #:____________________________

Marital Status: □ Married □ Single □ Divorced
□ Widowed □ Other

Occupation: ____________________________ Employer: ______________________________

Home Phone: ________________ Work Phone: __________________ Cell: ________________

Email:____________________________________

INSURANCE INFORMATION

Policy Holder Name: ____

Address (if different from above): ____

Date of Birth: _________________ Social Security #: ___________________________________

Employer: ____

AUTHORIZATIONS

BENEFIT TO PHYSICIANS:
I hereby authorize payments directly to the physician of the surgical and/or medical benefits. I also understand I am responsible for any portion of my bill not covered by my insurance company.

RELEASE OF INFORMATION:
I hereby authorize the release of medical information for treatment, prescriptions, and insurance claim purposes. A copy of the authorization is as valid as the original.

HIPPA ACKNOWLEDGEMENTS:
Protecting your confidential health information is important to us. This notice is to inform you of how we protect your health information and that you were offered a copy of our policy.

I understand all of the above and hereby state that the information is correct to the best of my knowledge. My signature indicates that I have read the above and grant the request of authorizations.

Date: ____________________ Signature: ____

****CONTINUE TO PAGE 2 ON BACK****

****PLEASE FILL OUT EVERY BLANK TO THE BEST OF YOUR ABILITY****

MEDICAL INFORMATION

Do you have any of the following health problems? (Check the problem)

□ Arthritis	□ High Cholesterol	□ Lupus
□ Asthma	□ High Blood Pressure	□ Cancer
□ Emphysema	□ Heart Disease	□ Hepatitis
□ Thyroid Disease	□ Ulcers	□ Kidney Disease
□ Diabetes	□ Bowel Disease	□Seizures

Do you smoke? □ Yes □ No **Do you drink? □ Yes □ No**

List your current prescription & non-prescription medications:
____
____
____

List any allergies to medications:____

List any surgeries you have had & dates:
____
____

Are there any disease which seem to run in your family? (please list family member)
____
____

Ocular (Eye) Medications prescription & non-prescription:
____

List any Ocular (Eye) surgeries you have had &dates:______________________________________
____

Do you wear glasses? □ Yes □ No

Contact Lenses? □ Yes □ No Contact Lens Information:_________________________________

Family Physician: ____

Referring Physician: ____

Pharmacy: ____________________ **Pharmacy Address(Cross Streets):** __________________________

Email: ____