☐ WLB ☐ MAN

JSRC | JERSEY SHORE RETINA CONSULTANTS

Jersey Shore Ophthalmology Retina Consultants, LLC dba Jersey Shore Retina Consultants ("JSRC")

NEW PATIENT DEMOGRAPHIC FORM

Patient Name: _____

Last First MI

Date of Birth: _____ SSN: _____

Home Address: _____

City: _____ State: _____ Zip: _____

E-mail address: _____

Occupation: _____ Employer: _____

Work Address: _____

City: _____ State: _____ Zip: _____

PHONE NUMBERS:		OK to leave a voice mail	DO NOT leave a voice mail
Home:	_____	☐	☐
Cell:	_____	☐	☐
Work:	_____	☐	☐

Preferred Primary Phone number to contact is (circle one): Home / Cell / Work

Emergency Contact: (Name) _____ (Phone) _____

Relationship_____

Referred by Dr. _____Phone #_____

Referring Doctor's Address _____

General Eye Care Doctor: _____Phone #_____

Primary Care Doctor/Provider: _____Phone #_____

Name of other doctors you see: _____

Patient's Name: _____ Date of Birth: _____

Please check

Race	Ethnicity	Marital Status
☐ Hispanic or Latino	☐ American Indian or Alaskan Native	☐ Single
☐ Not Hispanic or Latino	☐ Asian	☐ Married
☐ Unknown	☐ Black or African American	☐ Divorced
☐ Decline to Specify	☐ Native Hawaiian or Pacific Islander	☐ Legally Separated
	☐ White	☐ Widowed
	☐ Other Race	☐ Unknown
	☐ Decline to specify	

INSURANCE INFORMATION:

Name of **Primary** Insurance: _____

Group Number: _____ Member ID Number: _____

Name of **Secondary** Insurance: _____

Group Number: _____ Member ID Number: _____

Name of Primary Insured: _____ SSN of Primary Insured: _____

Date of Birth of **Primary** Insured: _____

What is your main reason for today's visit? _____

_____

Please list all eye surgeries you have had with dates, surgeon and which eye.

_____

_____

_____

_____

_____

Please list all eye drops you are currently taking

_____

_____

_____

_____

_____

Are you currently under the care of another eye care professional? If so, who?

_____

Patient's Name: _____ Date of Birth: _____

Please mark if you have:

☐ Glaucoma ☐ Macular Degeneration

☐ Diabetic eye disease ☐ Retinal detachment

Please list any other eye conditions you have. _____

_____

Preferred Pharmacy

Please indicate your preferred pharmacy:

Pharmacy Name: _____ Phone number: _____

Address: _____

City: _____ State: _____ Zip: _____

Smoking History	
Do you currently smoke?	_____
Have you ever smoked?	_____
Stopped smoking date	_____
Packs per day	_____
Height: _____ Weight: _____	

Do you drink alcohol? If so, how much? _____

Do you use any illicit substances? If so, which? _____

Past Medical History

Do you have, or have you ever been diagnosed with (check):

☐ Diabetes ☐ Stroke

☐ High blood pressure ☐ Heart Attack

☐ Cholesterol ☐ Alzheimer's Dementia

☐ Thyroid disease ☐ Migraine

☐ Cancer (please specify) _____

Please list any other medical problems that you have, with date of diagnosis, if it is resolved and how you are being or were treated. _____

_____

_____

Patient's Name: _____ Date of Birth: _____

Please list the type and date of any other surgeries you have had (non-eye surgeries). _____

_____

_____

Please list any **allergies** to medications you have: _____

_____

Please provide an up to date list of medication (with amounts [dosing] and how many times a day [frequency] if you know it).

Check here if listed separately ☐

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____

Patient's Name: _____ Date of Birth: _____

Family History: Check Yes or No, and explain an "yes" response, i.e., mother, father, sister, etc.

	Yes	No	Family Member		Yes	No	Family Member
Glaucoma				Diabetes			
Macular Degeneration				Hypertension			
Retinal Detachment				Stroke/Vascular			
Cardiac				Cancer			

Review of Systems - Please check each item Yes or No as it pertains to your health:

	Yes	No		Yes	No		Yes	No
EYES			**NEUROLOGIC**			**SKIN**		
Double Vision			Weakness			Rash		
Wavy vision			Headaches			Itch		
Floaters or Spots			Scalp Tenderness					
Seeing Flashes of light or floaters			Dizziness			**Infectious Disease**		
Pain			Paralysis of Extremities			HIV		
Decreased Vision			Tremor			Hepatitis (B or C)		
Sandy/Gritty Feeling or Dry Eyes			Tingling of fingers or toes			Lyme		
Excessive Tearing			**GENERAL HEALTH**			**MUSCULOSKELETAL**		
			Fever			Muscle Aches		
CARDIOVASCULAR			Weight Loss			Joint Pain		
Chest Pain / Angina			Fatigue			Difficult lying flat		
Shortness of Breath			Loss of Appetite			Why?		
Swelling of Feet/Hands								
Elevated Blood Pressure			**Ear, Nose, Throat**			**PSYCHIATRIC**		
Heart Murmur			Hearing Loss			Anxiety		
			Soar Throat			Schizophrenia		
ENDOCRINE			Runny Nose / Sinus			Bipolar Disorder		
Excessive Thirst						Depression		
Excessive Urination			**BLOOD / LYMPH**					
Heat Intolerance			Easy Bruising			**GENITOURINARY**		
Cold Intolerance			Prolonged Bleeding			Pain/Burning on Urination		
Uncontrolled Blood Sugar			**CANCER**			Blood in Urine		
			Location:_____			Frequent Urination		
RESPIRATORY			Radiation ☐ Chemotherapy ☐			Incontinence of bowel or bladder		
Wheezing								
Cough			**Gastrointestinal (Stomach/Intestines)**					
Recent Flu or Virus			Nausea					
Shortness of Breath			Stomach / Abdominal Pain					
Sleep Apnea			Diarrhea					

Tech Initials: _____ MD Initials: _____