Skippack Vision
610-584-4544
PATIENT INFORMATION SHEET

Patient Name__________________________________Patient Birthdate ____________Male____Female____
Address_____________________________________ City___________________ State _____ Zip __________
Social Security #___________________________ Email Address ____________________________________
Home(_____) _________________ Work (_____) ___________________ Cell (_____) ___________________
Emergency Contact_________________________________ Phone #__________________________________
Date of last eye exam___________ Occupation______________

Insured name and date of birth____

Who reffered you to our office?____

EYE INFORMATION
___Loss of Vision ___ Blurred Vision ___Double Vision ___Cataracts ___Floaters/Flashes
___Eye Pain ___Light Sensitivity ___ Chronic Infections ___Retinal Detachment ___Glaucoma
___ Dry Eyes ___Eyestrain Glare ___ Wear Glasses ___Wear Contacts ___ Eye Surgeries or Injuries
If any checked please explain ____

Are you in Good Health? ___yes ____no Are you pregnant? ___yes ____no _____ N/A
Name, address, and phone # of Primary Care Physician ____
Surgeries (what type and when) ____
Any allergic reactions to medications or other substances? ___ yes ___ no
If yes please explain ____
Do you smoke? ___yes ___ no How much? ____________ Do you use other substances? ___yes ___no
Do you drink alcohol? ___ yes ___ no How much? ______________
Do you have family history of any of the following? If yes, Please Check Box
___Diabetes ___Glaucoma ___High Blood Pressure ___Macular Degen. ___Retinal Detachment ___Cataracts
If checked, please explain and list relationship (maternal or paternal)

____
Do any of these conditions apply to yourself? Please list ____

PERSONAL MEDICAL INFORMATION: Do you have problems with any of these systems? If yes, please check.
___Allergy ___Cardiovascular ___Constitutional ___Endocrine(glands)
___Gastrointestinal ___Genitourinary ___Ears/Nose/Mouth/Throat ___Skin ___Immunologic
___ Musculoskeletal ___Neurological ___Mental ___Respiratory
Explain____
Do you take medications? ___yes ___ no
Please list names and how often____
Do you have any other medical conditions that aren't listed? ____

IF YOU HAVE VISION INSURANCE, PLEASE READ AND SIGN BELOW:
I authorize the release of any information necessary to process insurance claims. I understand I can revoke this consent by written request and that information released prior to revocation was made with my consent. I authorize payment directly to
Dr. Joseph Toth, O.D
I have reviewed all of the above information and it is correct to the best of my knowledge. I acknowledge that I received a copy of Joseph Toth, O.D. Notice of Privacy Practices.
Signed: ____ Date: ________________

iWellness: ($29, not a covered service on any insurance plan) Yes/No
Annual Contact Lens Evaluation ($78.00, not a covered service on most insurance plans): Yes/No
New Contact Fit $110.00 Training $40.00 Yes/No

Update Records: Initial ______________ Date____________ Initial______________ Date_______________