ROBINS EYE CARE, LLC
Anitha Kannan, O.D.
334 Margie Drive, Warner Robins, GA 31088

Name_____ **Sex:** M/F **Marital Status:** M S D W
Last First MI

Age:_____ **DOB**:_____ **SSN**:_____ **Preferred Language:** _____

Address:_____**City**:_____**State**:_____ **Zip**:_____

Phone:_____ **Work**:_____ **Cell**:_____

Is Texting OK? Yes / No **E-Mail:**_____

Race & Ethnicity : American Indian / Alaskan Native ☐ Asian ☐ Black / African American ☐
Declined to Specify ☐ Hispanic / Latino ☐ Native Hawaiian / Pacific Islander ☐ White ☐

*****PLEASE PROVIDE US WITH A CELL PHONE AND A WORK PHONE NUMBER*****

Employer:_____ **Occupation**:_____ **Referred by**:_____

Primary Care Physician_____ **Date of last Eye Exam**_____

Was it with Dr. Kannan?_____ **Previous Eye Doctor**:_____

MEDICAL INSURANCE:_____ **VISION INSURANCE:**_____

Policy Holder
Name:_____**DOB**_____**SSN**_____

Phone Number for Policy holder:_____

IF PATIENT IS UNDER 18 YEARS OF AGE

Name of Parent/Guardian:_____Relation To Patient:_____

Phone:_____ _____ _____
Home Work Cell

FINANCIAL AND INSURANCE COVERAGE

I will be responsible for any non-covered services, co-pays, co-insurance, and deductibles with my insurance. If refraction and contact lens fitting are not covered by my insurance, I agree to pay an additional fee. Unpaid balances after 30 days will be sent to Collections with a Collection Fee.

I ACKNOWLEDGE THAT I HAVE RECIEVED/VIEWED A COPY OF PRIVACY PRACTICE.

Signature:_____ Date:_____
Patient/Parent or Legal Guardian

NEXT PAGE

NAME:_____ , _____ **AGE**_____
Last First

Do you currently: Wear glasses ☐yes/no ☐
Prescription sunglasses ☐yes/no ☐
Contacts ☐yes/no ☐
Have you worn contacts in the past? ☐yes/no ☐
Are you interested in trying contacts? ☐yes/no ☐
Do you use a computer? ☐yes/no ☐ Hours Per Day _____

HEALTH HISTORY (Check all that Apply)

☐ Acid Reflux
☐ ADD/ADHD
☐ Allergies
☐ Arthritis
☐ Asthma
☐ Blood Pressure
☐ Cancer
☐ Cholesterol
☐ Depression
☐ Diabetes
☐ Headaches
☐ Heart Disease
☐ HIV/AIDS
☐ Migraine
☐ Sinus
☐ Skin Conditions
☐ STD
☐ Stroke
☐ Thyroid Problems
☐ Other Health Issues? Major Surgeries?

Social: Alcohol_____per_____ Tobacco _____packs per_____ Drugs _____

EYE HISTORY (Check all that Apply)

☐ Cataracts
☐ Crossed Eye
☐ Dry Eye
☐ Eye Injury
☐ Eye Surgery, Reason_____
☐ Glaucoma
☐ Lazy Eye
☐ Macular Degeneration
☐ Retinal Detachment
☐ Other Eye Problems

FAMILY HEALTH HISTORY	Relationship	**FAMILY EYE HISTORY**	Relationship
☐ Blood Pressure	_____	☐ Cataracts	_____
☐ Cancer	_____	☐ Crossed Eye	_____
☐ Diabetes	_____	☐ Glaucoma	_____
☐ Heart Disease	_____	☐ Lazy Eye	_____
☐ Migraine	_____	☐ Macular Degeneration	_____
☐ Stroke	_____	☐ Retinal Detachment	_____

DO YOU USE EYE DROPS? ☐Yes/NO☐ If yes, What drops do you use?_____

LIST ALLERGIES TO ANY MEDICATION(S)_____

PROVIDE COMPLETE LIST OF MEDICATIONS YOU TAKE WITH STRENGTHS AND DOSAGES:

_____

IF YOU HAVE A LIST OF MEDICATIONS, PLEASE PROVIDE A COPY TO THE FRONT DESK.