

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

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)

- | | |
|---|--|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Sinus |
| <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Skin Conditions |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> STD |
| <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other Health Issues? Major Surgeries? |

Social: Alcohol _____per_____ Tobacco _____packs per_____ Drugs _____

EYE HISTORY (Check all that Apply)

- | | |
|--|---|
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Crossed Eye | <input type="checkbox"/> Lazy Eye |
| <input type="checkbox"/> Dry Eye | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Eye Injury | <input type="checkbox"/> Retinal Detachment |
| <input type="checkbox"/> Eye Surgery, Reason _____ | <input type="checkbox"/> Other Eye Problems |

FAMILY HEALTH HISTORY

Relationship

- | | |
|---|-------|
| <input type="checkbox"/> Blood Pressure | _____ |
| <input type="checkbox"/> Cancer | _____ |
| <input type="checkbox"/> Diabetes | _____ |
| <input type="checkbox"/> Heart Disease | _____ |
| <input type="checkbox"/> Migraine | _____ |
| <input type="checkbox"/> Stroke | _____ |

FAMILY EYE HISTORY

Relationship

- | | |
|---|-------|
| <input type="checkbox"/> Cataracts | _____ |
| <input type="checkbox"/> Crossed Eye | _____ |
| <input type="checkbox"/> Glaucoma | _____ |
| <input type="checkbox"/> Lazy Eye | _____ |
| <input type="checkbox"/> Macular Degeneration | _____ |
| <input type="checkbox"/> 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.