

# DAVID B. BRILL, O.D., P.A.

## PATIENT INFORMATION

### Personal Information

Date \_\_\_\_\_ Social Security # \_\_\_\_\_

Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ I authorize the release of any information needed to process my insurance claim.

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone H \_\_\_\_\_ W \_\_\_\_\_

Occupation \_\_\_\_\_ Signed \_\_\_\_\_

### General

How did you learn about our office?  Newspaper  Radio  Television  Yellow pages  A Friend or Relative  
 Walk By  Insurance Company/Third Party Administrator  Other  I am a previous patient.  
 Referred by another patient. Referred by \_\_\_\_\_

### Health Information

Reason for this visit:  Routine Exam  Contact Lens fitting  Interested in Contact Lenses

Other (please explain) \_\_\_\_\_

Last Eye Exam \_\_\_\_\_ Dr. \_\_\_\_\_

Have you ever had any injury or surgery to or around your eyes?  Yes  No

Please describe \_\_\_\_\_

Last physical exam \_\_\_\_\_ Dr. \_\_\_\_\_

Are you currently taking any medications?  Yes  No (include eye drops, hormones and birth control)

Please list all medications: \_\_\_\_\_

### Family Health History: (Please check all that apply)

Do you wear contact lenses?  Yes  No

Are you pregnant?  Yes  No

	You	Blood Relative		You	Blood Relative
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	High / Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	Heart / Vascular Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Tumors	<input type="checkbox"/>	<input type="checkbox"/>
Color Blindness	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Intestinal / Digestive Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Asthma / Bronchitis / Lung Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Kidney / Liver Disorder	<input type="checkbox"/>	<input type="checkbox"/>	High / Low Blood Sugar	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>
Fainting / Dizziness	<input type="checkbox"/>	<input type="checkbox"/>			

By signing below I acknowledge that my records will be handled by Dr. Brill's staff.

Patient's Signature \_\_\_\_\_