CURRENT PATIENT MEDICAL HISTORY

Name:____ Birth Date______________________ Age_________

Address____ E-mail Address_______________________________

City/State/Zip_____________________________________ Primary Care Physician________________________

Phone: Home_________________________ Cell__________________________ Work ____________________

Preferred contacts for messages (mark all that apply): ❑Cell ❑Home ❑Work ❑E-mail ❑Text

Medications you are taking:❑none____

____

Allergies to medications: ❑none____ __________________

Major injuries, surgeries or hospitalizations since last exam: ❑None ❑Yes-Describe____________________________

____

New eye condition or medical diagnosis since last exam: ❑None ❑Yes-Describe______________________________

____

Any eye surgeries or eye injections since last exam? ❑None ❑Yes-Describe_______________________________

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Do you have diabetes, borderline or pre-diabetes, or diet-controlled diabetes? ❑Yes ❑No

Do you smoke? ❑Yes ❑No

For women, are you pregnant or nursing? ❑Yes ❑No

INSURANCE SIGNATURE ON FILE
I authorize Sandra Davidson, OD, Inc, to help me obtain payment from my insurance and I request that payment of these benefits be made on my behalf to her for any services and materials furnished. I understand that I am responsible for all services and materials provided even if my insurance does not pay as expected.

*Patient Signature*____ Date____________________

RELEASE OF EXAMINATION FINDINGS
I authorize Drs. Davidson or Keltner to send a report of my examination to my physician, referring doctor or referring Health Professional. I also authorize Drs. Davidson or Keltner to discuss the results of my examination to the following individuals:

Name	Relationship
______________________________________	______________________________________
______________________________________	______________________________________
______________________________________	______________________________________

*Patient Signature*____ Date____________________

I have received Sandra Davidson, OD, Inc's Patient Confidentiality Policy

*Patient Signature*____ Date____________________