



**Patient Personal and Medical History Information**

**Patient Information:**

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Birth Date: \_\_\_/\_\_\_/\_\_\_ Social Security #: \_\_\_/\_\_\_/\_\_\_ Cell Phone: \_\_\_\_\_  
 Name of Medical Doctor: \_\_\_\_\_ Dr.'s Phone: \_\_\_\_\_  
 Patient's Gender: Female \_\_\_ Male \_\_\_ Last Eye Exam: \_\_\_/\_\_\_/\_\_\_  
 Spouse's Name: \_\_\_\_\_ or Parent/Guardian's Name: \_\_\_\_\_  
 Patient's Employer: \_\_\_\_\_ or Student's Grade: \_\_\_\_\_ School: \_\_\_\_\_

**Insured's information: Without this information we will not be able to file a claim for your services.**

Medical Insurance: \_\_\_\_\_ Vision Insurance: \_\_\_\_\_  
 ID# \_\_\_\_\_ ID# \_\_\_\_\_  
 SS# \_\_\_\_\_ SS# \_\_\_\_\_  
 Insured's Name: \_\_\_\_\_ Insured's Date of Birth: \_\_\_/\_\_\_/\_\_\_

**Medical History**

Do you have any allergies to medications?  No  Yes If yes, explain: \_\_\_\_\_

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):  
 \_\_\_\_\_  
 \_\_\_\_\_

List all major injuries, surgeries and/or hospitalizations you have had: \_\_\_\_\_

List any of the following that you have had: crossed eyes, lazy eyes, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: \_\_\_\_\_

Are you pregnant and/ or nursing?  No  Yes  
 Do you wear glasses?  No  Yes If yes, how old is your present pair of lenses? \_\_\_\_\_  
 Do you wear contacts?  No  Yes If yes, how old is your present pair of lenses? \_\_\_\_\_  
 Type of contact lenses:  Rigid  Soft  Extended Wear  Other Are they comfortable?  Yes  No

**Family History**

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

Disease/Condition	No	Yes	?	Relationship To You
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____





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Family Eye Care  
Low Vision Rehabilitation

Doctors of Optometry



Members American  
Optometric Association

**Mid-Michigan Eye Care**  
**Scott M. Buckingham, O.D., P.C.**  
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**Notice of Privacy Practices**  
**Patient Acknowledgement**

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that the practice reserves the right to change the terms of its Notice of Privacy Practices and to make changes regarding all protected health information, resident at, or controlled by, the practice. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practices upon request.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Relationship to patient (if signed by a personal representative of patient)

\_\_\_\_\_