B. Athwal, MD H. Athwal, MD
L. Althwal, MD
14 Mule Road, Suite 1
Toms River, NJ 08753
Phone: 732-286-0900

Patient Questionnaire

Patient Name: _____ Account #: _____

Please circle the answers to the following questions:

1. Are you a smoker? Yes No
2. Did you have the Flu shot this year? Yes No
3. Had the Pneumonia shot within the past 5 years? Yes No
4. Do dry eyes interfere with your leisure/work activities? Yes No
5. Would you like to discuss treatments for dry eyes? Yes No
6. Have you experienced any of the following symptoms?
   Please check all that apply:

_____ Painful or sore eyes
_____ Tired eyes
_____ Eyes that feel gritty
_____ Frequent blinking
_____ Burning
_____ Tearing
_____ Redness
_____ Fans or vents increase irritation

ATHWAL EYE ASSOCIATES, PC
B. Athwal, MD H. Athwal, MD
14 Mule Road, Suite 1
Toms River, NJ 08753
Phone: (732) 286-0900 Fax: (732) 244-6063

ATHWAL EYE ASSOCIATES

ATHWAL EYE ASSOCIATES, PC
H. Athwal, MD
550 Rt. 530, Suite 19
Whiting, NJ 08759
Phone: (732) 350-9191 Fax: (732) 244-6063

Personal Information

How did you hear of Athwal Eye Center?

Patient Referral _____ Newspaper Ad _____ Doctor _____
Name *Name* *Name*

Other (be specific) _____

PERSONAL INFORMATION

Last Name _____ First Name _____ MI _____

Address _____ City _____ State ____ Zip _____

Home Phone # (____) _____ - _____ Cell Phone # (____) _____ - _____ Marital Status ____

Birthdate _____/_____/_____ Sex _____ Age_____ Ethnicity_____

Email Address _____

Social Security # _____ - _____ - _____ Occupation _____

Employer _____ Work Phone # (____) _____ - _____

Business Address _____

In case of emergency please call _____

Relationship _____ Phone _____ Cell _____

BILLING INFORMATION

Subscriber Information: Name _____ Birthdate _____/_____/_____

Social Security # _____ - _____ - _____ Phone # (_____) _____ - _____

Address _____ City _____ State ____ Zip _____

Employer _____

Insurance Company Policy # Group # Subscriber Relationship

1. _____

2. _____

3. _____

I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have answered the above questions and certify this information to be correct to the best of my knowledge. I authorize Athwal Eye Associates, PC to release any information and records to any insurance company, adjuster, attorney, or insurance commissioner. I authorize and request payment of medical benefits, including Medicare benefits, be make on my behalf to Athwal Eye Associates, PC for professional services and treatment rendered.

Print Name _____
Patient or responsible party

Signature _____ Date _____
Patient or responsible party

MEDICAL HISTORY (MHx) FORM

Name _____ Age _____ Date _____

Referring Doctor or Person _____

Eye History: Do you wear ___ Glasses? ___ Contact Lenses? Date of Last Eye Exam _____

Eye Problems:

Please check any of the following problems that you have:

___ Blurred or Poor Vision	___ Poor Night Vision	___ Gritty Sensation
___ Trouble Reading Signs	___ Glare from Lights	___ Tearing
___ Poor Depth Perception	___ Halos Around Lights	___ Itching or Burning
___ Trouble Identifying Colors	___ See Spots or Floaters	___ Eye Pain
___ Double Vision	___ See Light Flashes	___ Redness or Bloodshot
___ Other _____		

Please mark any condition you or a blood relative have. Indicate relationship. Check if none _____

You	Relative		You	Relative	
___	_____	Dry Eyes	___	_____	Macular Degeneration
___	_____	Glaucoma	___	_____	Retinal Detachment
___	_____	Cataracts	___	_____	Other

Eye Surgery Including Lasers: Have you ever had eye surgery? ____ Yes ____ No

If Yes, please describe and give date: _____

Eye Medications: Please List: _____

Drug Allergies: ___ None or Please List: _____

Medical History: Medical Doctor _____

Please mark any condition you or a blood relative have. Indicate relationship. Check if none _____

You	Relative		You	Relative	
___	_____	High Blood Pressure	___	_____	Heart Problem
___	_____	Diabetes			(Arrhythmia, Angina, Congestive Heart Failure)
___	_____	Stroke	___	_____	Lung Problems
___	_____	Arthritis			(Sarcoidosis, Emphysema, COPD, Asthma)
___	_____	Ulcers	___	_____	Thyroid Problems
___	_____	Others. Please List _____			

List all medicines: Including dosage (i.e. mg) & How many times taken daily.

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

List any Non-Ocular Surgery with Date: _____

Social History: Smoke (Cigarettes, Cigars, Pipe) _____ # Per Day. List any drugs:_____

Alcohol (Beer, Wine, Liquor) ____ Social or Indicate Daily Consumption _____

Review of Systems: (Circle or List Problems You Have in Any Area) Check here if none: _____

Constitutional & Integumentary: Fever, Weight Loss, Rash, Skin Disease, _____

Head/Neck: Sinus Problems, Post-Nasal Drip, Runny Nose, Dry Mouth, Hearing Loss, _____

Respiratory: Cough, Bronchitis, Shortness of Breath, Asthma, Emphysema, COPD, _____

Cardiovascular: Chest Pain, Congestive Heart Failure, Irregular Rhythm, _____

Gastrointestinal: Vomiting, Ulcers, Diarrhea, Bloody Stools, _____

Genitourinary: Genital Ulcers, Discharge, Kidney Stones, Blood in Urine, _____

Allergic/Immunologic & Blood/Lymphatic: Seasonal Allergies, Hay Fever, _____

Neurologic, Psychiatric & Musculoskeletal: Headache, Migraines, Paralysis, Joint Aches, _____