James V. Furicchia, M.D.
OPHTHALMOLOGIST

○ PATIENT INFORMATION FORM ○

Thank you for choosing our office! In order to serve you properly, we need The following information. All information will be confidential.

TODAYS DATE: ________________

Patients Name: ____
(LAST) **(FIRST)** **(MIDDLE)**

□ Male □ Female Date of Birth: Month______ Day______ Year_________

Martial Status: Single ____ Married ____ Divorced ____ Widow ____ Child ____

Spouse's Name: ____________________________________ Work #: ( ) ______________________
Area Code

Date of Birth: Month______ Day______ Year ______

Home Address: _____________________________________ Apt. #: ___________________________

City / State: ____ Zip: _____________________________

Home Phone: (______) _________________________ Cell: (_____) ____________________________

Work Phone: (______) ___________________ Social Security #: _________-_________-_____________

In case of emergency, notify: _________________________ Relationship: _____________________________

Phone Number: (____) ___________________ Cell Number: (_____) ____________________________

If under the age of 18:
Parent(s) or guardian(s) Names: ____
Address, if different: ____
Phone, if different: ____

Primary Care Physician: _________________________ Phone #: (_____) ____________________________

Address: ________________________________City / State: _____________________________________

Responsibility for Bill: **Self Pay:** □

Primary Insurance Co.: ________________________________ ID#: ______________________________
Secondary Insurance Co.: ______________________________ ID#: ______________________________

Insured Employer: ___________________________________ Phone: ______________________________

List any allergies to Medications:

____

____

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Do you or a family member have a history of the following?

	FAMILY	**MYSELF**
Glaucoma	Yes / No	Yes / No
Cataract	Yes / No	Yes / No
“Lazy eye” muscle imbalance	Yes / No	Yes / No
Retinal Disease	Yes / No	Yes / No
Macular Disease	Yes / No	Yes / No
Color Blindness	Yes / No	Yes / No
Unexplained Visual Loss	Yes / No	Yes / No
Diabetes	Yes / No	Yes / No
Tumor or Cancer	Yes / No	Yes / No
High Blood Pressure	Yes / No	Yes / No
Heart Disease	Yes / No	Yes / No
Cigarette Smoking	Yes / No	Yes / No how long?

How did you hear about us? ☐ Newspaper ☐ Radio ☐ Advertisement ☐ Billboard ☐ Website ☐ Phonebook ☐ Other ____________

Is there anyone we can thank for referring you to 20/20 Eye Center? ___________________

**In accordance with the HIPAA act, a copy of our Privacy Policy is provided on the following Page **

Acknowledgement of HIPAA:

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I have read the notice of privacy practices given to me by **20/20 Eye Center, Doctor James V. Furicchia, MD**. I understand how **20/20 Eye Center, Dr. James V. Furicchia, MD** will use my protected heath information for treatment, payment, and healthcare operations. I have been provided with a copy **of 20/20 Eye Center, Dr James V. Furicchia, MD’s** notice of privacy practices.

Print Name: ____ **Date of Birth:** ________________

Signature: ____ **Today’s Date:** ________________

_______**Staff Initials**