ARCHIBALD R. MORRIS, OD
GIFFORD S. PIPER, OD
125 Manor Drive - Ebensburg, PA 15931
814-472-9670

PATIENT DEMOGRAPHIC INFORMATION

Name: ______________________ Primary Care Physician: ______________________

Address: ______________________ Last Physical Exam: __________ Pharmacy: __________

City: ______________ Zip: __________ Last Eye Exam if not here: __________ Location: __________

Home Phone: __________ Cell: __________ Birth Date: __________ E-mail: __________

Gender: ______ Marital Status: ______ Emergency Contact: ______________________ Phone: __________

Patient's Soc Sec: # ______________ Employed ____ Employer: ______________________ Retired ____

INSURANCE INFORMATION

Primary Medical Insurance: ______________________ Primary Vision Insurance: ______________________

Employee or Main Cardholder's Name: ______________________ Relationship to Patient: __________

Cardholder's Social Security Number: ______________________ Cardholder's Date of Birth: __________

Secondary Medical: ______________________ Secondary Vision ______________________

PATIENT MEDICAL HISTORY (Check all that apply.)

____ Headaches	____ Hypertension	____ High Cholesterol	____ Stroke	____ Diabetes
____ COPD	____ GERD	____ Arthritis	____ Thyroid Problems	____ A1C ______
____ Asthma	____ Anxiety	____ Depression	____ MS	____ Psoriasis
____ Herpes	____ Lyme's Disease	____ Tuberculosis	____ Epilepsy	____ Arthritis
____ Bladder Issues	____ STDs	____ Rosacea	____ Blood Clots	____ Pregnant (now)
____ Allergies, seasonal	____ Other ______________		____ Leukemia	____ Breastfeeding(now)

Eye Surgeries (R or L) & dates: ______________________

Other Surgeries & dates: ______________________

Medications (We will copy your list, if desired.) ______________________

____

Medication Allergies: ______________________

Tobacco: Never Used Quit- ____ # years ago Current ____ years Contact Lens Wearer: Yes/No Glasses: Yes/No

Alcohol Use: None Social Frequent Blood Transfusion: Yes/No Narcotic Use: None Recreational Dependent

PATIENT FAMILY HISTORY

Please note family history and relation to the patient.

Blindness ______________________ Diabetes ______________________

Cataract ______________________ Heart Disease ______________________

Glaucoma ______________________ High Blood Pressure ______________________

Macular Degeneration ______________________ Thyroid Disease ______________________

Lazy Eye ______________________ Arthritis ______________________

Patient Signature ______________________ **Date** __________

Doctor Signature ______________________ **Date** __________