PORT HURON EYE INSTITUTE
Fahim K. Ibrahim, MD, PC Kamal Fahim, MD, PLC

PATIENT NAME:_____DOB: _____/_____/_____ SEX_____
Last First

SOCIAL SECURITY #:_____-_____-_____ MARITAL STATUS:_____LANGUAGE:_____

HOME ADDRESS:_____
Street City State Zip

PREFERRED PHONE:_____OTHER PHONE:_____

EMAIL ADDRESS:_____RACE:_____ ETHNICITY:_____

SPOUSE NAME:_____ DOB (SPOUSE):_____/_____/_____

EMERGENCY CONTACT:_____PHONE:_____

PRIMARY CARE PHYSICIAN:_____REFERRED BY:_____

PHARMACY NAME & LOCATION: _____

PRIVACY PRACTICES AND RELEASE OF INFORMATION

I have been informed about and offered a copy of Port Huron Eye Care Notice of Privacy Practices.
My Protected Health Information may be shared with the following individuals (Do not list yourself):

NAME:_____RELATIONSHIP:_____

NAME:_____RELATIONSHIP:_____

NAME:_____RELATIONSHIP:_____

☐ I authorize phone calls (including voicemail) AND email for purposes of follow up care and scheduling.
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ASSIGNMENT OF BENEFITS AND FINANCIAL POLICY

I authorize the release of any medical or other information necessary to process claims on my behalf. I agree to be fully responsible for all debts incurred by myself for services received by Port Huron Eye Care (Fahim Ibrahim, MD, PC and/or Kamal Fahim, MD, PLC) whether covered by my insurance or not. I understand that Port Huron Eye Care filing claims on my behalf does not necessarily mean that they participate with my insurance; therefore, I may be responsible for payment.
REMEMBER, a medical insurance policy is a contract between the patient and an insurance company. "Out of pocket" costs (copays, deductibles) are based on that contract. Port Huron Eye Care must abide by the contract.

CONSENT FOR TREATMENT

I voluntarily consent to treatment; including examinations and testing. No guarantees have been made regarding the results of such treatment. I understand that for an eye examination or testing, my eyes will be dilated which may interfere with my vision while walking or driving. It is my sole responsibility to have an escort and to use sunglasses if needed. Port Huron Eye Care will not be liable if I am involved in any accident or injury to others or myself.

PATIENT SIGNATURE:_____DATE:_____

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HISTORY QUESTIONAIRE

Height: _____ Weight: _____ Last Blood Pressure (if known): _____

Eye Problems:	**Review of Systems:**	**Family History:**
❑ Blurry Vision	❑ Consitutional (fatigue, fever)	❑ Lazy Eye
❑ Burning	❑ Respiratory (asthma, cough)	❑ Blindness
❑ Double Vision	❑ Cardiovascular (chest pain, leg swelling)	❑ Cataracts
❑ Drooping Eye Lid	❑ Gastrointestinal (constipation, nausea/vomiting)	❑ Glaucoma
❑ Eyelid Lesion	❑ Genitourinary (urinary infections)	❑ Macular Degeneration
❑ Flashes & Floaters	❑ Metabolic/Endocrine (heat/cold intolerance)	❑ Retinal Disorders
❑ Foreign Body Sensation	❑ Neurological (weakness, headache)	❑ Strabismus
❑ Glare	❑ Psychiatric (depressed mood, stress)	❑ High Blood Pressure
❑ Irritation	❑ Integumentary (skin rash)	❑ Diabetes
❑ Pain	❑ Musculoskeletal (muscle/joint pain)	❑ Heart Disease
❑ Red Eye	❑ Hematologic/lymphatic (bleeding/brusing)	❑ Arthritis
❑ Tearing	❑ Immunologic (food/seasonal allergies)	❑

Ocular Medications (Eye Drops/Ointment):

_____

_____

_____

Allergies to Medications:

❑ No Known Allergies

_____

_____

Please List Current Medications:

_____

_____

_____

_____

_____

_____

_____

Medical Illnesses:

❑ Diabetes

❑ High Blood Pressure

❑ Other:

Past Surgeries (including eye surgeries):

_____

_____

_____

_____

_____

Smoking Status:

❑ Current Smoker ❑ Former Smoker ❑ Never Smoked ___ Packs Per Day

Alcohol Use:

❑ Frequently ❑ Occasionally ❑ Rarely

Caffeine Use:

____ Cups Per Day

We look forward to helping care for your eyes. Welcome to our office!