5776 Dow Ave
Alexandria, VA 22304

Name: ______________________________________ D.O.B ______________________ Date: _____________

Address: _____________________________________City:___________________ Zipcode: _______________

E-mail: __________________________ Cell Phone: _____________________ Occupation: __________________

SSN: ____________________ Insurance? Y / N Insurance Provider: ______________ ID: ___________________

Primary Language: English / Spanish / French / Amharic / Farsi / Other: ______________________
Smoking Status: Never Smoker / Former Smoker / Current Someday Smoker / Current Everyday Smoker
Is this a medical visit? Y / N (spots, flashes of light, cataracts, glaucoma, diabetes, redness, pain)

Race:	Ethnicity:
White Black or African American	
Asian American Indian or Alaska Native	Hispanic or Latino. Not-Hispanic or Latino
Native Hawaiian or Other Pacific Islander	Unknown Decline to Answer
Other: Decline to Answer	

PATIENT HEALTH HISTORY

Married: Y / N Pregnant: Y / N Alcohol: Y / N Drugs: Y / N

Do you take any Medications? Y / N ____

Do you take any eye drops? Y / N ____

Are you allergic to any medications? Y / N ____

Have you had eye surgery? Y / N ____

Any family history of: Glaucoma / Macular Degeneration / Lazy Eye / Retinal Detachment / Other: ________________

Do you have any chronic health conditions such as: Diabetes / High Blood Pressure / Arthritis / High Cholesterol / Asthma / Emphysema / Thyroid / Dry Eye / Dry Mouth / Headaches / Migraines / Anxiety / Depression / Other: ________

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the practitioner. I understand that I am financially responsible for any balance. I also authorize Anthony B. Kouchak O.D. or insurance company to release any information required to process my claims.

Patient/Guardian Signature: ____ Date: ___________________________