**WELCOME TO THE OFFICE OF DR. WILLIAM DOTY and DR. PATRICK DOTY**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Nickname**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth**: \_\_\_\_ /\_\_\_\_\_ /\_\_\_\_\_

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State:** \_\_\_\_\_ **Zip**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ cell *\_\_Y \_\_N* **Alternate Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ cell *\_\_Y \_\_ N*

**E-mail Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Preferred Contact** (circle one): *Phone Email* *Text*

**Social Security** #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Gender**: *\_\_Male \_\_Female* Height: \_\_\_\_\_ Weight: \_\_\_\_\_\_

**Marital Status**: *\_\_Married \_\_Single \_\_Divorced \_\_Legally Separated \_\_Widowed*

**Employment Status**: \_*\_FT \_\_PT \_\_Self Employed \_\_FT Student \_\_ PT Student \_\_Retired \_\_Not Employed*

**Employer**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Care Physician**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Referred to us by**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pharmacy:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Location (street & city)**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Race (check one)**: *\_\_\_ American Indian \_\_\_Asian \_\_\_Black or African American*

 *\_\_\_White \_\_\_Unspecified*

**Ethnicity (check one)**: *\_\_\_ Hispanic \_\_\_ Not Hispanic \_\_\_Native Hawaiian or other Pacific Islander*

**Preferred Language (check one)**: *\_\_\_English \_\_\_French \_\_\_Spanish \_\_\_Japanese \_\_\_Portuguese*

**Guarantor/Responsible Party**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information**

**Medical Provider Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary insured: \_\_ *Self \_\_Other*

 If Other, Name of insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to the insured: *\_\_ Spouse \_\_ Child \_\_Other*

**Vision Provider** (if any): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary insured: *\_\_ Self \_\_Other*

If Other, Name of insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to the insured: *\_\_ Spouse \_\_ Child \_\_Other*

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**Allergies**

Allergen\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_Mild \_\_Moderate \_\_Severe

Allergen\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_Mild \_\_Moderate \_\_Severe

**Past Ocular History (Please mark all that apply)**

\_\_Overall Healthy \_\_Cataracts \_\_Hyperopia \_\_Myopia

\_\_Amblyopia (lazy eye) \_\_Diabetic Retinopathy \_\_Iritis \_\_Optic Neuritis

\_\_Aphakia \_\_Dry Eyes \_\_Keratoconus \_\_Retinal Detachment

\_\_Astigmatism \_\_Glaucoma \_\_Macular Degeneration

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ocular Surgeries (Please mark all that apply)**

\_\_No Prior Ocular Surgery \_\_Foreign Body Removal \_\_Punctal Plugs \_\_LASIK

\_\_Blepharoplasty \_\_Retinal Laser Surgery \_\_RK \_\_Vitrectomy

\_\_Cataract Surgery \_\_Strabismus Surgery \_\_PRK (eye muscle surgery)

\_\_Corneal Transplant \_\_Trabeculectomy (Glaucoma Surgery)

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ocular Significant Illnesses (Please mark all that apply)**

\_\_Overall Healthy \_\_Herpes \_\_Hypothyroidism \_\_Sjogrens

\_\_AIDS \_\_HIV Positive \_\_Lupus \_\_Graves Disease

\_\_Diabetes \_\_Hypertension \_\_Multiple Sclerosis \_\_Hyperthyroidism

\_\_Rheumatoid Arthritis

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Eye Medications (Please list all):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Systemic Illnesses (Please mark all that apply):**

\_\_No History of illness \_\_Congestive Heart Failure \_\_Hepatitis \_\_Lung Disease

\_\_Anemia \_\_COPD \_\_High blood pressure \_\_Lupus

\_\_Arthritis \_\_Diabetes \_\_High Cholesterol \_\_Migraine

\_\_Arrhythmia \_\_Eczema \_\_HIV \_\_Polymyalgia

\_\_Asthma \_\_Fibromyalgia \_\_Kidney disease \_\_Psychiatric Disorder

\_\_Bleeding Disorder \_\_Headache \_\_Kidney Stones \_\_Skin Cancer

\_\_Cancer \_\_Hearing loss \_\_Liver Disease \_\_Stroke

\_\_Thyroid Disease

**Other:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**General Surgeries/Operations (Please list all**):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other Current Medications: (Please list all**):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Infections (Please mark all that apply):**

\_\_Overall Healthy \_\_Herpes Simplex \_\_HIV/AIDS \_\_Syphilis

\_\_Chicken Pox \_\_Herpes Zoster/Shingles \_\_Meningitis \_\_Toxoplasmosis

\_\_Hepatitis A/ B/ C \_\_Histoplasmosis \_\_MRSA \_\_Wound Infection

 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History for First Degree Relatives (parent, child, sibling)**

\_\_Arthritis \_\_Diabetes \_\_Kidney Disease \_\_Stroke

\_\_Blindness \_\_Glaucoma \_\_Lazy Eye \_\_TB

\_\_Cancer \_\_Heart Disease \_\_Macular Degeneration

\_\_Cataracts \_\_High Blood Pressure \_\_Retinal Disease

 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History (Please mark all that apply)**

Smoking: \_\_Current every day smoker \_\_Current some day smoker \_\_Former smoker \_\_Never smoked

Alcohol Use: \_\_Yes \_\_No If yes, what and how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug Use: \_\_ Yes \_\_No If yes, what and how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Review of Systems (Please mark all that apply)**

**Eyes Respiratory Blood/Lymphatic**

\_Previous Surgery \_Cough \_Easy bruising

\_Contact Lens \_Congestion \_Gums bleeding easy

\_Pain \_Wheezing \_Prolonged bleeding

\_Double Vision \_Asthma \_Heavy aspirin use

\_Glaucoma

\_Cataracts **Gastrointestinal Musculoskeletal**

\_Macular Degeneration \_Heartburn \_Stiffness

\_Dry Eyes \_Nausea/Vomiting \_Arthritis

\_Flashes \_Jaundice/Hepatitis \_Joint pain/Swelling

\_Floaters

 **Genitourinary Skin**

**Ear, Nose, and Throat** \_Pain/Difficulty \_Rash/Sores

\_Hard of hearing \_Blood in urine \_Lesions

\_Ringing in ears \_History of kidney stones \_Hives/Eczema

\_Vertigo \_History of STD’s

 **Neurological**

**Cardiovascular Psychiatric** \_Seizures

\_Chest Pain \_Anxiety/Depression \_Weakness/Paralysis

\_Dizziness \_Mood swings \_Numbness

\_Fainting spells \_Difficulty sleeping \_Tremors

\_Shortness of breathe

\_Irregular heart beat **Endocrine Immunologic**

\_Difficulty lying flat \_Increased thirst \_Hives

 \_Increased hunger \_Itching

**Constitutional** \_Increased sweating \_Runny Nose

\_Fatigue/Weakness \_Fingernail changes \_Sinus Pressure

\_Fever

\_Weight gain/Loss

**INSURANCE COVERAGE OR PRIOR AUTHORIZATION WAIVER**

***If you do not have your insurance card today:***

I understand that since I do not have my current insurance card, my exact coverage cannot be verified. I also understand that if my insurance is a referral plan, or if my plan requires prior authorization, I will be held responsible for today’s bill.

***If you have not received prior authorization:***

I understand that under my insurance plan, a referral from my primary care physician may be necessary prior to seeing Dr. Doty. Since the referral or prior authorization could not be verified today, I understand that I may be held responsible for payment.

Today’s visit is for: (check one)

\_\_ Exam related to vision, glasses or contacts

\_\_ Medical, state reasons: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signed: *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* Date: *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***I have read or received a copy of Dr. William T. Doty’s notice of Privacy Practice.***

**Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Please Note: Insurance may cover only part of your charges. If we do not accept direct payment from your insurance plan, you will need to pay our office and submit your receipt for reimbursement from your insurance company. If your insurance does not pay as directed, you are ultimately responsible for all charges. We cannot be responsible if you are not eligible for benefits.*