Complete forms electronically and print before closing, or print blank forms and complete manually. You will not be able to save the completed electronic forms.

Wills Eye Hospital

Neuro-Ophthalmology Service

Patient Resources - About Your Visit

Please read the following information. Your appointment may be rescheduled if we do not have all required information. Please plan to spend several hours for your appointment. Additional testing may need to be performed in addition to the examination.

- Please bring all medications and eyewear.
- Please bring records from previous physicians related to the reason for your visit.
- If you have had a CT, MRI, or other radiology testing you MUST bring the films/CD and written reports with you to your appointment. Please note that the written reports alone are not enough! Our doctors personally review all imaging studies. It is very important to bring the films or CDs or we may need to reschedule until we have the films.
- If you have had any blood work related to the reason for your visit, please bring the results with you to your appointment.
- Bring the name, address, and fax number of any physicians or individuals to whom you would like a report of your visit sent.
- Please complete the Patient History and Patient Demographic Information forms BEFORE YOUR VISIT and bring the completed forms with you to the appointment. If you do not bring the forms with you, it may delay your visit.
- We participate with most major insurance plans but insurance participation may vary based upon the office location. It is the patient's responsibility to confirm insurance coverage. Bring your insurance cards and appropriate referrals if needed.
- Payment for services not covered by insurance, including copay amounts, will be collected at the time of the visit.
- If your condition is related to an accident or a Workman's Compensation injury, you must contact our office PRIOR to your visit. If we do not have appropriate prior authorization and documentation, your visit will be rescheduled.

If you have any questions, please call the office at which your appointment is scheduled.

We make every effort to see patients at their scheduled time. However, because we provide all neuro-ophthalmology services for Wills Eye Hospital and Thomas Jefferson University Hospital, on occasion there may be delays because of life or sight threatening emergencies. We appreciate your patience and understanding and look forward to meeting you and participating in your care.

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PATIENT DEMOGRAPHIC INFORMATION FORM

Please print clearly.

Patient Name	First Name, Middle Initial, Last Name				
Address					
City, State ZIP					
Phone	Home	Cell		Work	
Gender *(select from list)*		Date of Birth *(m/d/yyyy)*		SSN	
Email		Occupation			
Employer Name and Address					

Medical Insurance			
ID No.		Group No.	
Name of Subscriber		Subscriber DOB *(m/d/yyyy)*	
Relation to Subscriber			

Referring Physician		Specialty	
Address			
City, State ZIP			
Phone No.		Fax No.	

Primary Care Physician			
Address			
City, State ZIP			
Phone No.		Fax No.	

Please list all additional physicians who you would like to receive a report of your visit on another page.

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PATIENT HISTORY FORM

Patient's Name: ______________________________ Birth Date: ______________

Reason for your visit: ______________________________ Visit Date: ______________

For office use only
Reviewed
Physician Signature: ______________________________ Date: ______________

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR MEDICAL HISTORY:	YES	NO
Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, arthritis)? ***If Yes, please explain***	☐	☐
Have you ever had any eye disease (e.g., glaucoma, cataract, wandering or "lazy" eye, retinal detachment)? ***If Yes, please explain***	☐	☐
Have you had a recent radiology testing of your head (e.g., CT, MRI)? ***If Yes, you MUST bring the films or CD(s) to your visit***	☐	☐
Have you ever had any surgery? ***If Yes, please provide date and reason***	☐	☐
Have you ever been hospitalized? ***If Yes, please provide date and reason***	☐	☐
Do you take any medications? ***If Yes, please list***	☐	☐
Do you take any eye medications? ***If Yes, please list***	☐	☐
Are you currently taking any blood thinners (Coumadin, warfarin, aspirin, baby aspirin, Plavix, clopidogrel, etc) or any herbal supplements? ***If so, please list in detail***	☐	☐
Do you have any drug or food allergies? ***If Yes, please list***	☐	☐

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PATIENT HISTORY FORM

Patient's Name: ______________________________ Visit Date: ______________

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING PROBLEMS:	YES	NO	IF YES, PLEASE EXPLAIN:
Chronic fever, unexpected weight loss/gain, fatigue	☐	☐	
Ear/nose/throat problems (e.g., hearing loss, sinus problems, sore throat)	☐	☐	
Heart problems (e.g., chest pain, irregular heart beat)	☐	☐	
Respiratory problems (e.g., shortness of breath, wheezing, coughing)	☐	☐	
Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea, vomiting)	☐	☐	
Urinary problems (e.g., pain or discomfort, blood in urine)	☐	☐	
Skin problems (e.g., rashes, excessive dryness)	☐	☐	
Musculoskeletal problems (e.g., muscle aches, joint pain, swollen joints)	☐	☐	
Neurologic problems (e.g., numbness, weakness, headaches, paralysis, vertigo)	☐	☐	
Psychiatric problems (e.g., depression, anxiety)	☐	☐	
Diabetes or other endocrinological disorders	☐	☐	
Anemia or other blood disorders	☐	☐	

FAMILY AND SOCIAL HISTORY:	YES	NO	IF YES, PLEASE EXPLAIN:
Do any medical or eye diseases run in your family (e.g., diabetes, high blood pressure, cancer, glaucoma, macular degeneration)?	☐	☐	
Do migraines run in your family?	☐	☐	
Do you currently smoke? If Yes, how much?	☐	☐	
Have you ever smoked? If Yes, indicate how much, how long, and when you stopped.	☐	☐	
Do you drink alcohol? If Yes, how much?	☐	☐	
Do you or have you ever used recreational drugs?	☐	☐	