Offices of Dr. David Epp

102 E. Main, Sayre, OK 73662
117 E. 3rd, Shamrock, TX 79079

Full Name_____ Preferred Name_____

Parent's Name or Responsible Party_____

Mailing Address_____City/State/Zip_____

Cell Phone_____ OK to text? ☐ Yes ☐ No

Other Phone_____ Email_____

DOB _____/_____/_____ SSN _____ Sex: ☐ Male ☐ Female

Marital Status: S M D W Spouse Name_____ Spouse Phone_____

Occupation _____ Employer_____ Work Phone_____

Please present insurance card to be copied or complete:
Insurance_____ Insured's Name_____
Insured's Address_____
Insured's SSN_____Insured's DOB_____

HEALTH QUESTIONS:

Which of the following are you experiencing today or taking medication to control?
Eye pain

- ☐ Tearing
- ☐ Loss of vision
- ☐ Fever
- ☐ Dry mouth
- ☐ High blood pressure
- ☐ Rapid heartbeat
- ☐ Shortness of breath
- ☐ Increased frequency of urination
- ☐ Joint pain
- ☐ Autoimmune disease
- ☐ Changing moles
- ☐ Headache
- ☐ Learning disabilities
- ☐ Autism
- ☐ Seizure
- ☐ Stroke
- ☐ Anxiety
- ☐ Depression
- ☐ Diabetes
- ☐ Thyroid abnormalities
- ☐ Allergies

List other medical diagnoses are not listed above:

What surgeries have you had since you last filled out an information sheet for our office?

Have you had any of the following procedures?

	Approximate date
☐ Lasik	_____
☐ Cataract surgery	_____
☐ Laser after cataract surgery	_____
☐ Procedure to lower eye pressure	_____
☐ Injection into eye	_____

Have you had any eye injuries?

_____

Have you or a family member been told that you have any of the following eye conditions?

Lazy eye	_____you	_____Family member_____
Glaucoma	_____you	_____Family member_____
Macular degeneration	_____you	_____Family member_____
Cataract	_____you	_____Family member_____
Dry eye	_____you	_____Family member _____

Other eye conditions that you have: _____
Other conditions that family members have: _____

Dr. Epp can import a list of medications from your pharmacy for most patients. Does he have your permission to import your medication list?

- ☐ Yes
- ☐ No

If you think that you use a pharmacy that we may not have access to, be prepared to share a list of medications with the doctor.

Allergies to medications_____

Other allergies _____

Which of the following best describes your experience with smoking:

☐ Never smoked? ☐ Former smoker? ☐ Smoke occasionally? ☐ Smoke every day?

I acknowledge that I was offered/or received a copy of Dr. David Epp's Notice of Privacy Practices:

Signature Date