

McAlester Family Eyecare 211 N 5th St • McAlester, OK 74501

(918) 426-0106

Dr. Andrea Mazzare, O.D. & Dr. Jeff Duff, O.D.

General Information										
Please bring your insurance card and a valid I.D. to check-in.										
First, Last, MI, F	Preferred Name:									
Street Address	:									
City, State, Zip:										
If you are unde	r 18, parent or legal	guardi	an's na	me:						
Phone 1:				☐ Cell		Home		Business	Mi	ay we text you?
Phone 2:				□ Cell		Home		Business		Y or N
Email:										
Sex: M or F Date of			te of B	irth:		Social Security:			/ :	
Preferred Language: English; Other:					Ethnicity: Non-Hispanic or Latino/Hispanic/Hawaiian or Pacific Islander					
Race:										Decline to Specify
Preferred Contact Method:				☐ Email		□Р	ostal		☐ Phone	☐ No Preference
Insurance Information										
Employment St	atus:				Emp	oloyer:				
Occupation:			Ma	Marital Status:						
Policy Holder's (PH) Name:				(P	(PH) DOB: (PH) S				(PH) SSN:	
Policy Holder's	Address (if differer	ıt):								
				Soc	ial Info	rmati	on			
Please check th	ne following if applic	able:		Hobb	ies:					
Tobacco use:	e: Current Smoker PPD: Smokeless Tobacco Former Smoker res		you h repri giver resp	Note: Most Insurance companies pay only a portion of your total charges. If you have any questions about your coverage, please contact your representative. We do not guarantee the accuracy of benefit information given to us by insurance companies. Please understand that financial responsibility of your account is yours, not the responsibility of your insurance company. I authorize the release of any medical or other information necessary						
Alcohol use: None Social only How many drinks per day?		to process insurance claims. I authorize the payment of medical or vision benefits either to a physical or supplier of services rendered or to myself if the provider does not accept assignment. I understand that I am responsible for any balance my insurance does not pay.								
Weight:					,	,			1-	
Are you Pregnant or Nursing? Yor N			\neg	Sign	Signature:					Date:



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	Signed:	Date:	

E	ye History	y		Primary Care Physician:					
Date of Last Exam: Uncorrected visual blur: Clear/mild/mod Computer use:[hrs per da		°e		Please list any past major surgeries (systemic and ocular):					
Currently wear glasses?			-	Medication Allergies:					
Currently wear contacts			-	Wiedication 7 Metgles.					
Reason for today's visit:									
Have you of your family r treated for any of the fol	lowing? Plea	ise circle a	l that apply:	Have you or a family member experienced, or been treated for, and the following? Please circle all that apply: (if "other" please specials.	ny of :ify)				
Cataracts:	YES	NO	Family	Diabetes: YES NO Family					
Crossed Eye:	YES	ND	Family	High Blood Pressure: YES NO Family	NONE				
Glaucoma:	YES	ND	Family	Allergy: Seasonal Other:	NUNE				
LASIK or PRK:	YES	NO	Family	Other:	NONE				
Lazy Eye:	YES	NO	Family	Other:	NONE				
Macular Degeneration:	YES	NO	Family	Other:	NONE				
Retinal Detachment:	YES	NO	Family	Gastrointestinal: Crohn's Dz Colitis Acid reflux Ulcer Other:	NONE				
Other: (Please Specify)					NONE				
				Other:	NONE				
Curre	nt Medica	tions		Hematologic/Lymphatic: Anemia Leukemia Other:	NONE				
Please list prescription an	d DTC (or inc	lude capy at	current list)	Immunologic: Rheumatoid Arthritis AIDS Lyme Dz Other:	NONE				
				Integumentary: Eczema Rosacea Psoriasis Other:	NONE				
				Other:	NONE				
				Other:	NONE				
				Other:	NONE				
				Respiratory : Asthma Bronchitis Emphysema Other:	NONE				