



EYE PHYSICIAN AND SURGEON
Diplomate American Board of Ophthalmology

Patient Information

Last Name _____ First Name _____ Middle Initial _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____
SS# _____ Birthdate _____ Male Female
Occupation _____ Employer _____
Spouse's Name _____ Primary Care Physician _____

Responsible Party (If different from above)

Last Name _____ First Name _____ Middle Initial _____
Address _____
City _____ State _____ Zip _____
SS# _____ Employer _____

Illnesses or Conditions You Have Had

- Arthritis
- Asthma
- Bleeding Tendencies
- Cancer
- Diabetes
- Emphysema
- Other _____
- Heart Problems
- Hepatitis/Liver Disease
- High Blood Pressure
- HIV/AIDS
- Kidney Disease
- Neurological Disease
- Pregnant (*Currently*)
- Stomach/Intestinal Disease
- Stroke
- Thyroid Disease
- Tuberculosis

Eye History

- Cataract
- Corneal Diseases
- Eye Surgery
- Glaucoma
- Lazy Eye
- Retinal Disease
- Other _____

Do you have a family history of glaucoma? Yes No If Yes who? _____

List medications you are currently taking, including eye drops _____

List medications you are allergic to _____

Do you have a history of: Alcohol Use Drug Use Tobacco Use

How Did You Hear About Dr. Tozer?

Doctor Referral - Name _____ Family/Friend - Name _____
Phone Book _____ Other _____

Insurance Information

Name of Insurance Company (*Please present your insurance card*) _____

Please sign below for proper filing of your insurance claim.

I authorize the release of any medical information necessary to process this claim. I also request payment to government benefits either to myself or the party who accepts assignment.

Signature _____ Date _____

I authorize payment of medical benefits to Randall K. Tozer , M.D. for services provided.

Signature _____ Date _____