SUSAN M. HUGHES, M.D

General Patient Information

Todays date: _____

Name: ***Date of Birth:*** ***(Age)***

Address: ***Social Security #:***

City/State/Zip: ***Cell Phone: ( )***

Home Telephone: ( ) ***Business: ( )***

Marital Status: **M S W** ***Gender:*** **M F** ***Do you have Children:*** **Y N**

How Were You Referred?: (Circle) 1. Courier Post 2. Web Site 3.Phila. Inquier 4.Web MD 5.Yellow Pages 6.Other _____

Email Address: _____

Primary Insurance Information:

Policy #: ***I.D. #***

Guarantors Info: (WHO IS THE SUBSCRIBER TO THE INSURANCE POLICY)

Name: ***Social Security #:***

Address:

Telephone: ***Date of Birth:***

Secondary Insurance Information:

Policy #: ***I.D. #:***

Attorney's Name (If applies): ***Telephone: ( )***

Address:

The following Information MUST be completed. Please (Doctor's Full Name, Address & Telephone # Necessary)

Referring Doctor: (First) ***(Last)*** Circle ***MD DO Telephone: ( )***

Address:

Family Doctor: (First) ***(Last)*** ***MD DO Telephone: ( )***

Address:

Eye Doctor: (First) ***(Last)*** ***MD DO Telephone: ( )***

Address:

Other Physicians: (First) ***(Last)*** ***OD MD DO OD Telephone: ( )***

Address:

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Dr. Susan M. Hughes to furnish information to insurance carriers concerning my illness and/or injury and I hereby assign to the Physician, payments for medical services rendered to my dependents or myself. I understand that I am responsible, at the time of service, for payment of office visits and procedures and/or any amount not covered by my Insurance for Hospital Procedures.

Date: _____ ***Signature:*** _____

***FULL Reason for your Consultation*:**

History of Present Illness (If Any):

Past Medical History:

Do you have a Lazy Eye: ☐ ***Yes*** ☐ ***No or other eye problems:*** ☐ ***No*** ☐ ***Yes, please list:***

Please list any previous COSMETIC SURGERY, Doctors Name: ☐ ***None***

List all OTHER Surgeries with Dates: ☐ ***None***

Medications & Dosage: (***Include over the counter medication***) ☐ ***None or please list:***

When you go to the dentist, do you require multiple anesthesia shots: ☐ ***Yes*** ☐ ***No***

***Drug Allergies (Please list allergic reaction)*:**

Have you ever had: Hepatitis B: ☐ ***Yes*** ☐ ***No*** ***Hepatitis C:*** ☐ ***Yes*** ☐ ***No*** ***HIV:*** ☐ ***Yes*** ☐ ***No***

Pharmacy:
Address & Telephone:

Social History
Occupation (if RETIRED, please list previous careers):
Name of Employer _____

Spouses Name:
Spouses Occupation (if RETIRED, please list previous careers):

Do you Smoke? ***Yes No*** ***If yes, how many per day?***
Alcohol Consumption? ***Yes No*** ***If yes, how much & how often?***

In Case of Emergency (Two (2) REQUIRED):
1. Name: ***Relationship:***
Address & Telephone:

2. Name: ***Relationship:***
Address & Telephone:

Do we have your permission to leave a message on your answering machine and/or with family members?

_____ ***yes*** _____ ***no*** ***PLEASE SIGN:*** _____