

WELCOME TO OUR OFFICE

Patient Information (Please complete this form to give us the information needed to serve you. If you need assistance please ask for help.) Please print

Name _____ Date _____
 First MI Last
 Address _____ City _____ State _____ Zip _____
 Birth date _____ Sex Male/Female Social Security No. _____ Home phone# _____
 Employer _____ Occupation _____ Work phone # _____
 Business Address _____ City _____ State _____ Zip _____

Reason for today's visit _____

Responsible Party Who is responsible for this account ? _____
 Relationship to patient _____ Home phone # _____ Work phone # _____

Other household members who are patients here _____

Medical History

Last eye exam date _____ Last medical exam date _____ Dr's name _____

Check any of the following that apply to you or your family

	You	Family		You	Family		You
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant	<input type="checkbox"/>		Blur at a distance	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	Blur when reading	<input type="checkbox"/>
Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Double vision	<input type="checkbox"/>
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Spots/floaters	<input type="checkbox"/>
Lung problems	<input type="checkbox"/>	<input type="checkbox"/>	Retinal detachment/disease	<input type="checkbox"/>	<input type="checkbox"/>	Distorted vision/halos	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Flashes of light in my eyes	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Eye surgery	<input type="checkbox"/>	<input type="checkbox"/>	Computer eyestrain	<input type="checkbox"/>
HIV positive	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Glare bothers me	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Burning /stinging/itch	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Eye injury	<input type="checkbox"/>		Dry or gritty eyes	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Temporary loss of vision	<input type="checkbox"/>	<input type="checkbox"/>	Tearing	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Blindness	<input type="checkbox"/>	<input type="checkbox"/>	Mucous discharge	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Crossed or lazy eyes	<input type="checkbox"/>	<input type="checkbox"/>	Redness	<input type="checkbox"/>
Vascular disease	<input type="checkbox"/>	<input type="checkbox"/>	Loss of side vision	<input type="checkbox"/>	<input type="checkbox"/>	Eye infection	<input type="checkbox"/>

Please list any medications you are taking _____

Please list known allergies (including medicines) _____

Have you ever been dilated? yes no How long ago? _____ Any adverse reaction? _____

Do you currently wear glasses? yes no If yes, how old is the present pair? _____

When do you wear your glasses? All the time Distance only Reading/near work Computer work
 Work Safety Other, please explain _____

Have you worn contacts? yes no Do you wear them currently? yes no If yes, how old is are they? _____

Are you interested in wearing contacts? yes no

If yes, what style? Soft Astigmatic Daily Wear Extended Wear Disposable Colors
 Gas Permeable Bifocal Not Sure

Do you work at a computer? yes no If yes, how many hours daily? _____

What hobbies or sports do you participate in? _____

Do you need safety eyewear for work/hobbies? yes no

*** Please turn this form over and complete side two ***

Insurance Information

Name of insured _____ Relationship to patient _____ Birth date _____
Name of employer _____ Social Security # _____ Date employed _____
Address _____ City _____ State _____ Zip _____ Phone # _____
Insurance Co. _____ Group # _____ Employer # _____
Insurance Co. address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max annual benefit? _____
DO YOU HAVE ADDITIONAL INSURANCE? No Yes IF YES PLEASE COMPLETE THE FOLLOWING :
Insurance Co. _____ Group # _____ Employer # _____
Insurance Co. address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max annual benefit? _____

HOW DID YOU HEAR ABOUT US? TV RADIO NEWSPAPER YELLOW PAGES REFERRAL
LOCATION MAIL OFFER PREVIOUS PATIENT EYE EXAM REMINDER OTHER _____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eye care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor insurance benefits otherwise payable to me. I understand that my eye care insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X

SIGNATURE OF PATIENT (Or parent if a minor)

DATE