

PATIENT INFORMATION

Please Print

Today's Date _____ Patient Name _____ SS# _____

Mailing Address _____ City _____ State _____ Zip _____

Sex: M F Age _____ Birth Date _____ Single Married Widowed

Home Phone _____ Work Phone _____ Occupation _____

Employer _____ Cell Phone _____

Parent Name (If minor) _____ Spouse Name _____

Reason For Today's Visit? _____

Does Today's Visit Involve Testing and Evaluation For Contact Lenses? Yes* No

**If yes, please initial here if you understand that there will be an additional charge _____*

EYE HISTORY

Eye Physician's Name _____ Date of Last Eye Exam _____

Do you wear glasses? Yes No All the time Occasionally Reading Driving TV

Do you wear contacts? Yes No Brand/Type _____ Hours/Days _____

Describe any problems you have with your contacts _____

Please mark the box if you are currently experiencing any of the following

Blurred Vision— <u>Distance</u> <input type="checkbox"/>	Blurred Vision— <u>Near</u> <input type="checkbox"/>	Burning Eyes <input type="checkbox"/>	Poor Color Vision <input type="checkbox"/>
Crossed Eyes <input type="checkbox"/>	Discharge from Eyes <input type="checkbox"/>	Double Vision <input type="checkbox"/>	Dry Eyes <input type="checkbox"/>
Eye Infection <input type="checkbox"/>	Red Eyes <input type="checkbox"/>	Floaters or Spots <input type="checkbox"/>	Headaches <input type="checkbox"/>
Itching Eyes <input type="checkbox"/>	Light Sensitivity <input type="checkbox"/>	Poor Night Vision <input type="checkbox"/>	Temporary Loss of Vision <input type="checkbox"/>
Seeing Halos <input type="checkbox"/>	Seeing Flashes <input type="checkbox"/>	Twitching Eyelid <input type="checkbox"/>	
Watering Eyes <input type="checkbox"/>	<i>Other</i> <input type="checkbox"/> <i>List</i> _____		

GENERAL HEALTH HISTORY

Family Physician's Name _____ Date of last visit _____

Please place a mark to indicate if you *and/or* a blood relative currently has or has had any of the following conditions

	You / Family Member		You / Family Member		You / Family Member	
AIDS/HIV <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis <input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve <input type="checkbox"/>	<input type="checkbox"/>
Cancer (<i>If yes, below</i>) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type _____			Diabetes <input type="checkbox"/>	<input type="checkbox"/>	Drug Sensitivity <input type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy <input type="checkbox"/>	<input type="checkbox"/>
Eye Surgery <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin Conditions <input type="checkbox"/>	<input type="checkbox"/>	Hay Fever <input type="checkbox"/>	<input type="checkbox"/>
Glaucoma <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (Type____) <input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure <input type="checkbox"/>	<input type="checkbox"/>
Cataracts <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headaches <input type="checkbox"/>	<input type="checkbox"/>	Pacemaker <input type="checkbox"/>	<input type="checkbox"/>
Retinal Disease <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke <input type="checkbox"/>	<input type="checkbox"/>	Shingles <input type="checkbox"/>	<input type="checkbox"/>
Corneal Disease <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Condition <input type="checkbox"/>	<input type="checkbox"/>	Thyroid Conditions <input type="checkbox"/>	<input type="checkbox"/>
Eye Injury <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Premature Birth <input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis <input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis <input type="checkbox"/>	<input type="checkbox"/>	Other _____ <input type="checkbox"/>	<input type="checkbox"/>

If Female, are you pregnant? Yes No

- Please Continue On Other Side -

MEDICATIONS**ALLERGIES**

List medications you are currently taking
Including eye drops

List your allergies to medications or other substances

Pharmacy Name _____

Phone _____

INSURANCE INFORMATION

How will you pay for today's visit? Cash MasterCard / Visa Insurance Coverage

Name of Person Responsible for this Account _____ Relationship _____

Vision Care Insurance _____ Major Medical Insurance _____

Group # _____ Group # _____

Member # _____ Member # _____

Subscriber Name / Birthdate _____ Subscriber Name / Birthdate _____

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the physician and I am financially responsible for all non-covered services. I am also responsible for costs incurred in collection of any non-assigned fees. I authorize the physician to release any information required to process my insurance claims.

Signed _____ Date _____

•How Were You Referred To Our Office? _____

•We are presently in the process of developing a data base of our patients e-mail addresses in order that we may send periodic updates and specials that will not be offered to the general public. If you have an e-mail address and would like to be included in our data base, please indicate that address here: _____@_____.
Your address will be used solely by our office and will not be sold or given to anyone.

**THANK YOU FOR FILLING OUT THIS FORM**

If you have minor children, have they had their first complete eye exam yet? (Not school screening). Yes No