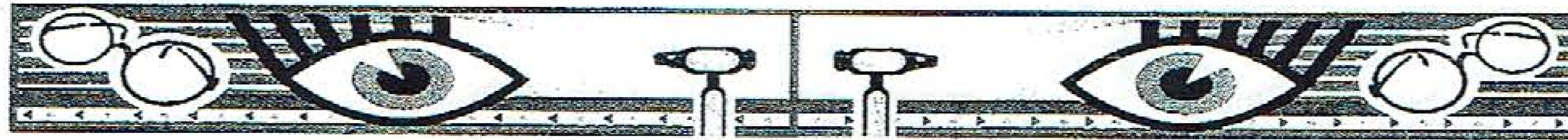


WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out both sides completely.
If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your health.

PATIENT INFORMATION

DATE______________________________

NAME______________________________

BIRTH DATE____/____/____ GENDER __M __F

SOCIAL SECURITY#______________________

ADDRESS______________________________

CITY______________ STATE_____ ZIP________

MAILING ADDRESS______________________

CITY______________ STATE_____ ZIP________

HOME PHONE (______)______________________

CELL PHONE (______)______________________

WORK PHONE (______)______________________

IF YOU HAVE INSURANCE-Please Fill Below

PLEASE CHECK ONE:

○ Married ○ Single ○ Divorced ○ Widowed ○ Minor

Is Patient a College Student: ○ Yes ○ No

FULL-TIME STUDENT: ○ Yes ○ No

Who Can We Notify In Case of an Emergency?

Name________________ Relationship____________

Home Phone (________)____________________

Cell Phone (________)____________________

PRIMARY VISION INSURANCE

○ Self ○ Spouse ○ Other

Name of Insured__________________________

Vision Insurance Company__________________

Policy #_________________________________

Group/Union#____________________________

Social Security # of Employee______________

Employee's Birth Date______/______/______

Employer or Company Name_________________

Address__________________________________

City______________ State__________ Zip________

ADDITIONAL VISION INSURANCE

○ Self ○ Spouse ○ Other

Name of Insured__________________________

Vision Insurance Company__________________

Policy #_________________________________

Group/Union#____________________________

Social Security # of Employee______________

Employee's Birth Date______/______/______

Employer or Company Name_________________

Address__________________________________

City______________ State__________ Zip________

PATIENT EYE HISTORY

Year of Last Eye Exam:____________________

Doctor___________________________________

City of Dr.'s Location_____________________

Do You **Wear/Have** Glasses at the Moment? ○ Yes ○ No

How old Are your glasses___________________

Glasses are worn: ○ Always ○ Sometimes ○ Reading ○ Driving ○ Computer ○ Never

FOR CONTACT LENS USERS ONLY

Do You Wear Contacts? ○Yes ○No

If Yes, How Old Are Your Present Lenses______________

What is Your Replacement Schedule:

○ Constantly ○2 Weeks ○Monthly

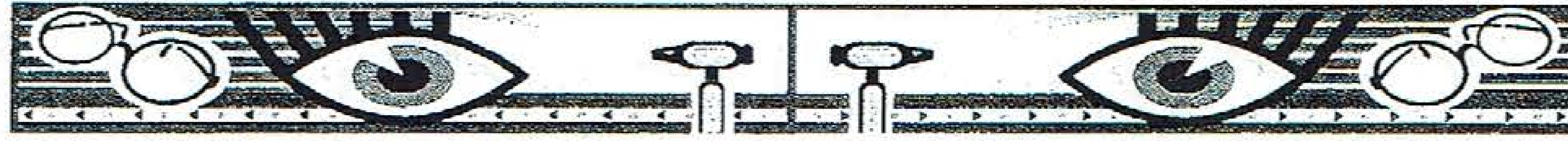
What Type of Lenses Do You Wear

○ Soft ○ Rigid ○ Toric ○ Dailies ○ Extended Wear

Brand Name_______________________________

What Contact Solution Do You Use___________

PLEASE CONTINUE ON BACK SIDE



VISION PROBLEMS

CHECK IF YOU HAVE ANY OF THE FOLLOWING:

- O Blurred Vision
- O Double Vision
- O Flashes of Light
- O Floaters in Vision
- O Complete Loss of Vision
- O Light/Glare Sensitivity
- O Loss of Side Vision
- O Distorted Vision/Halos

CHECK IF APPLICABLE:

- O Infection of Eye or Lid
- O Sandy or Gritty Feeling
- O Foreign Body Sensation
- O Excess Tearing/Watering
- O Itching
- O Redness
- O Discharge
- O Tired Eyes
- O Pain
- O Burn
- O Sties
- O Dryness

PERSONAL and FAMILY OCULAR DISEASE HISTORY:

SELF:	FAMILY:
__ Blindness	__ Blindness
__ Cataracts	__ Cataracts
__ Glaucoma	__ Glaucoma
__ Crossed Eyes	__ Crossed Eyes
__ Ocular Allergies	__ Ocular Allergies
__ Retinal Detachment	__ Retinal Detachment
__ Macular Degeneration	__ Macular Degeneration

FAMILY MEMBER RELATION TO YOU:

____
____
____
____
____
____
____

PERSONAL HEALTH HISTORY:

List Any Medications You are Taking

____
____

CHECK IF APPLICABLE:

- O High Blood Pressure
- O General Allergies
- O Heart Disease
- O Cancer
- O Asthma
- O Depression/Anxiety
- O Thyroid Disease
- O Diabetes
- O Arthritis
- O Lupus

Are You Allergic to Any Medications? O Yes O No

____

Primary Care Doctor Name & PH # OR Location

____
____

List Any Other Health Problems Not Mentioned:

____

List Any Eye Injuries You Have Had:

____

Do You Drive? O Yes O No

Do You Use A Computer Often? O Yes O No

Do You Use Tobacco Products? O Yes O No

Do You Have Visual Difficulty When Driving? O Yes O No

Are You Pregnant or Nursing? O Yes O No

Do You Drink Alcohol? O Never O Occasional O Frequently

AUTHORIZATION

I authorize my insurance company to pay to the doctor or medical group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
I authorize the doctor to release all information necessary to secure the payment of benefits.
Not all services provided in this office are covered in all insurance contracts.
I understand that I am financially responsible for all charges whether or not paid by the insurance.

SIGNATURE*: ______________________________ DATE: ____/____/____

*(If patient is younger than 18, a parent or guardian **must** sign)

PARENT/GUARDIAN SIGNATURE: ______________________________ DATE: ____/____/____

THANK YOU!!