Patient Information Date:_____

Name:_____ Date of Birth:_____Sex: M / F

Address:_____

City:_____ State:_____ Zip:_____ Home Phone:_____

Occupation:_____ Cell Phone:_____

Email Address: _____

Name of Spouse or Parent:_____

Family Physician:_____ Physician Phone:_____

Insurance Information

Vision Insurance Provider:_____

Primary Insured Name:_____ FOR OFFICE USE ONLY:

Primary Insured SS #:_____ _____

Health Insurance Provider:_____ _____

Referral Needed: Y / N _____

Health History

Reason for being here today: _____

How often do you use a computer?_____ Read?_____

Do you wear glasses? Y / N How old is the prescription in your glasses?_____

Do you wear contacts? Y / N What brand?_____

How often do you sleep in your contacts? _____

How often do you replace your contacts?_____ Type of Solution Used:_____

When was your last eye exam?_____ Where?_____

List any eye injuries:_____Date:_____Eye: R / L

List any eye surgeries:_____ Date:_____ Eye: R / L

List anyone in your family who had/has any of the following eye conditions:

Glaucoma:_____Macular Degeneration:_____

Retinal Detachment:_____Strabismus/Lazy Eye:_____

Cataracts:_____

List ANY Eye drops you use:_____

List your MEDICATIONS:_____

List your medication ALLERGIES:_____

Please **CIRCLE** any of the following that you have now or previously have been diagnosed with:

High Blood Pressure	Headaches	Irregular Heartbeat	Eye Pain	Dry Eyes
Diabetes	Facial Palsy	Sinus Problems	Itchy Eyes	Sleep Apnea
Hypoglycemia	Parkinson's	Heart Disease	Alzheimer's	Anemia
Double Vision	Glare Problems	Blurred Vision	Lost Vision	Asthma
Prostate Problems	Kidney Disease	Liver Disease	Thyroid Disease	Stroke
Hard of Hearing	Heart Attack	Depression	Eye Discharge	Cancer

I request payment of authorized Medicare or other Insurance be made either to me or on my behalf to the Doctor for any services rendered to me. I authorize any holder of medical information about me to be released to The Health Care Financing Administration and its Agents any information needed to determine these benefits payable for related services. I also understand that if my insurance company or other responsible parties refuse payment that I the patient or legal guardian of assume full financial responsibility for the services rendered.

DATE:_____PATIENT SIGNATURE:_____