PATIENT INFORMATION

PATIENT_____ DATE_____

ADDRESS_____ CITY_____ STATE _____ ZIP_____

HOME PHONE _____ WORK/CELL PHONE _____

BIRTHDATE _____ PATIENT SS# _____

MARITAL STATUS: SINGLE MARRIED MINOR OTHER _____ SEX: M F

EMPLOYER/ SCHOOL_____ OCCUPATION/ GRADE _____

EMERGENCY CONTACT _____ EMERGENCY NUMBER _____

REFERRED BY: _____email:_____

INSURANCE/ RESPONSIBLE PARTY

PERSON RESPONSIBLE _____ RELATIONSHIP TO PATIENT _____

ADDRESS (SAME AS ABOVE__) _____ SS# _____

VISION INSURANCE _____ EMPLOYER_____

SUBSCRIBER _____ BIRTHDATE _____ ID#_____

MEDICAL INSURANCE _____

SUBSCRIBER _____ BIRTHDATE _____ ID#_____

SECONDARY INSURANCE _____

SUBSCRIBER _____ BIRTHDATE _____ ID#_____

ASSIGNMENT AND RELEASE

I, the undersigned, assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that Iam financially responsible for all charges not paid by insurance. Payment for services, glasses, and contacts are due, in full, unless other arrangements have been agreed upon. I hereby authorize the use of this signature on all insurance submissions.

_____ _____

RESPONSIBLE PARTY SIGNATURE DATE

REASON FOR TODAY'S VISIT _____
LAST EXAM _____ BY WHOM _____
DO YOU WEAR: GLASSES CONTACTS BOTH NONE DO YOU HAVE SUNGLASSES OR CLIP-ONS? Y N
IF YOU WEAR CONTACT LENSES; TYPE/ BRAND _____ CLEANING SYSTEM_____
ARE YOU INTERESTED IN CONTACTS? Y N
IF YES, ARE YOU INTERESTED IN: DISPOSABLES? SLEEPING WITH? COLOR? OTHER? _____
ARE YOU INTERESTED IN CORRECTIVE SURGERY? Y N
DO YOU HAVE TROUBLE WITH GLARE OR REFLECTIONS? Y N
DO YOU WORK ON A COMPUTER? Y N
HOBBIES/ SPORTS _____

HEALTH HISTORY

Please complete the following to the best of your knowledge. It is necessary for us to have complete knowledge of all medications and physical ailments to provide the best care for your eyes and vision. Many medications have ocular/ visual side effects, though usually rare, and some systemic diseases/ disorders may also contribute or be related to the eyes. Thank you for your cooperation.

PLEASE CHECK ALL THAT APPLY

1. HAVE YOU OR ANY BLOOD RELATIVE BEEN DIAGNOSED AND/ OR TREATED FOR THE FOLLOWING?

Conditions	Self yes	Self no	Family yes	Please Describe - How Long?/ Which Relative?
Diabetes				
High Blood Pressure				
Thyroid Conditions				
Heart Conditions				
Glaucoma				
Macular Degeneration				
Eye Turn and/or Lazy Eye				
Blindness				
Cataracts				

2. HAVE YOU BEEN DIAGNOSED WITH AND/ OR TREATED FOR ANY OF THE FOLLOWING? (PRESENT AND PAST)

Conditions	Yes	No	How Long?, When?,etc
High Cholesterol			
Stroke			
Neurological/ Nerve Disorders			
Psychological/ Psychiatric			
Respiratory/ Breathing			
Gastrointestinal			
Genitourinary			
Ear, Nose, Throat, Mouth			
Skin			
Musculoskeleton			
Cancer/ Immune System			
Other- Medical			
Eye Infections			
Eye Surgery			
Eye Injuries			
Eye conditions (not listed)			
Other- eye			

3. PLEASE LIST MEDICATIONS, ALSO OVER THE COUNTER, VITAMINS, ETC

Medications	For Treatment of
Eye Drops	How much/often

ALLERGIES: TO MEDICATIONS _____ OTHER_____
TOBACCO USE: YES, HOW MUCH _____ NO PREVIOUSLY ALCOHOL USE: NEVER OCCASIONAL MODERATE DAILY
PEDIATRIC/BIRTH (IF APPLICABLE) PREMATURE Y N IF YES,_____ WEEKS _____BIRTH WT OXYGEN AT BIRTH Y N
PRIMARY CARE PHYSICIAN_____ OFFICE LOCATION_____
FOR WOMEN ONLY: ARE YOU PREGNANT? Y N IF YES, HOW LONG? _____ ARE YOU NURSING? Y N

I, the undersigned, agree to update this office with any changes that may occur with my health and/ or use of medications. I have completed this form to the best of my knowledge.

_____ _____
SIGNATURE DATE

OFFICE USE ONLY
REVIEWED BY/ DATE_____