Welcome to our Office!

1. Patient Information Date:_____

Last Name:_____ First Name:_____ Middle Initial____
Address:_____ City:_____ State:_____ Zip:_____
Sex: ☐ Male ☐ Female Age:_____ Date of Birth_____ Social S. #_____
Marital Status: ☐Married ☐Widowed ☐Single ☐Minor ☐Separated ☐Divorced ☐Other
Occupation_____ ☐ Student If yes, grade:_____
Employer:_____
Employer/School Address:_____ Employer/School Phone:_____
Spouses Name:_____ Date of Birth_____ Social S. #_____
Spouses Employer:_____
How did you hear about us? ☐Former Patient ☐Referred by:_____ ☐Radio
☐Phone Book ☐Doctor Referral Other:_____
How may we contact you?
Home Phone:_____ Cell Phone:_____ Work Phone:_____
E-Mail:_____ Best time and place to reach you:_____
In case of an emergency who may we contact?
Name:_____ Relationship:_____
Home Phone:_____ Cell Phone:_____ Work Phone:_____
Who is responsible for this account?
☐Myself
☐Other: Name_____ Relationship to Patient:_____
Address:_____ City:_____ State:_____ Zip:_____
Date of Birth_____ Social S. #_____ Phone:_____

Physician's Name:_____ Phone #_____

2. Vision Insurance Information
Vision Insurance Name:_____
Address:_____ City:_____ State:_____ Zip:_____
Name of Insured:_____ Sex: ☐ Male ☐ Female
Address:_____ City:_____ State:_____ Zip:_____
Date of Birth_____ Social S. #_____ Phone:_____
Relationship to Patient ☐Self ☐Spouse ☐Parent ☐Other:_____
Insured ID Number:_____ Group Number:_____
Employer:_____ Address:_____
How much is your Co-Pay Amount $_____ How much is your Deductible: $_____
How much have you used: $_____ Max. Allowance: $_____

3. Medical Insurance Information
Insurance Name:_____
Address:_____ City:_____ State:_____ Zip:_____
Name of Insured:_____ Sex: ☐ Male ☐ Female
Address:_____ City:_____ State:_____ Zip:_____
Date of Birth_____ Social S. #_____ Phone:_____
Relationship to Patient ☐Self ☐Spouse ☐Parent ☐Other:_____
Insured ID Number:_____ Group Number:_____
Employer:_____ Address:_____
How much is your Co-Pay Amount $_____ How much is your Deductible: $_____
How much have you used: $_____ Max. Allowance: $_____

4. Do you have additional Vision or Medical Insurance? ☐Yes ☐No

If Yes, please complete the section below:
Insurance Name:_____
Address:_____ City:_____ State:_____ Zip:_____
Name of Insured:_____ Sex: ☐ Male ☐ Female
Address:_____ City:_____ State:_____ Zip:_____
Date of Birth_____ Social S. #_____ Phone:_____
Relationship to Patient ☐Self ☐Spouse ☐Parent ☐Other:_____
Insured ID Number:_____ Group Number:_____
Employer:_____ Address:_____
How much is your Co-Pay Amount $_____ How much is your Deductible: $_____
How much have you used: $_____ Max. Allowance: $_____

5. Assignment & Release

I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any change in my medical status, I will inform the doctor. I authorize my insurance company to pay the doctor all insurance benefits otherwise payable to me, or my dependent(s), 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. I understand that I am financially responsible for all charges whether or not paid by insurance.

- For insurance plans in which we are participating, all co-pays & deductibles are due at the time of service. INITIAL_____
- Please be aware that some, and perhaps all services may not be covered and that you are responsible for you bill. INITIAL_____

_____
Signature of Patient, Parent, or Guardian, or Personal Representative

_____
Please Print Name of Patient, Parent, or Guardian, or Personal Representative

_____ _____
Date Relationship to Patient

6. Eye Health & History

Reason for Today's Exam:_____
Date of last eye exam:_____ Previous Eye Doctor:_____
Do you wear Glasses? ☐Yes ☐No If yes, do you wear them: ☐All the time ☐Occasionally
☐Reading ☐Driving ☐TV ☐Computer work
Are you interested in Contacts? ☐Yes ☐No Do you wear currently wear Contacts? ☐Yes ☐No
If yes, what Type/Brand:_____
How often do you wear your contacts?_____ Do you wear them overnight? ☐Yes ☐No
Describe any problems you have with your contacts:_____
Have you ever had eye surgery? ☐Yes ☐No If yes; please describe:_____
Are you interested in LASIK surgery? ☐Yes ☐No

Please mark 'Yes' or 'No' to indicate if you have, or have you ever had, any of the following:

Blurred distance vision (driving, TV)	☐Yes	☐No	Seeing halos	☐Yes	☐No
Poor night vision	☐Yes	☐No	Headaches	☐Yes	☐No
Blurred near vision (reading, computer)	☐Yes	☐No	Tired eyes or Eye Strain	☐Yes	☐No
Double vision	☐Yes	☐No	Droopy Lids	☐Yes	☐No
Sensitivity to light or glare	☐Yes	☐No	Twitching of the eyelid	☐Yes	☐No
Itching around the eyes	☐Yes	☐No	Poor color vision	☐Yes	☐No
Burning eyes	☐Yes	☐No	Dizziness	☐Yes	☐No
Eye irritation	☐Yes	☐No	Fainting spells / blackouts	☐Yes	☐No
Watery eyes	☐Yes	☐No	Temporary loss of vision	☐Yes	☐No
Dry eyes	☐Yes	☐No	Eye Injury	☐Yes	☐No
Red eyes	☐Yes	☐No	Eye infection	☐Yes	☐No
Eye Pain	☐Yes	☐No	Eye Discharge	☐Yes	☐No
Seeing Flashes or Flickering lights	☐Yes	☐No	Eye Turn or Crossed	☐Yes	☐No
Seeing Floaters or Spots	☐Yes	☐No			

Please list any other eye problems:_____

7. Health History

Please indicate if you or any of your family members have had any of the following problems:

	Yourself		Family Member	
Eyes:				
Eye Surgery	☐Yes	☐No	☐Yes	☐No
Cataracts	☐Yes	☐No	☐Yes	☐No
Glaucoma	☐Yes	☐No	☐Yes	☐No
Macular Degeneration	☐Yes	☐No	☐Yes	☐No
Retinal Detachment	☐Yes	☐No	☐Yes	☐No
Lazy Eye	☐Yes	☐No	☐Yes	☐No
Poor Color Vision	☐Yes	☐No	☐Yes	☐No
Blindness	☐Yes	☐No	☐Yes	☐No
General:				
Fever, Weight Loss/Gain	☐Yes	☐No	☐Yes	☐No
Skin:				
Skin Cancer	☐Yes	☐No	☐Yes	☐No
Eczema	☐Yes	☐No	☐Yes	☐No
Psoriasis	☐Yes	☐No	☐Yes	☐No
Acne Rosacea	☐Yes	☐No	☐Yes	☐No
Shingles	☐Yes	☐No	☐Yes	☐No
Other Skin Disease:	☐Yes	☐No	☐Yes	☐No
Neurologic:				
Migraines	☐Yes	☐No	☐Yes	☐No
Multiple Sclerosis	☐Yes	☐No	☐Yes	☐No
Seizures	☐Yes	☐No	☐Yes	☐No
Meningitis	☐Yes	☐No	☐Yes	☐No
Neuritis or Neuralgia	☐Yes	☐No	☐Yes	☐No
Nervous Breakdown	☐Yes	☐No	☐Yes	☐No
Psychiatric Care	☐Yes	☐No	☐Yes	☐No
Endocrine:				
Hyperthyroidism	☐Yes	☐No	☐Yes	☐No
Hypothyroidism	☐Yes	☐No	☐Yes	☐No
Diabetes	☐Yes	☐No	☐Yes	☐No
Cancer	☐Yes	☐No	☐Yes	☐No
Ears, Nose, & Throat:				
Allergies	☐Yes	☐No	☐Yes	☐No
Sinus Problems	☐Yes	☐No	☐Yes	☐No
Dry throat/mouth	☐Yes	☐No	☐Yes	☐No
Ear Problems	☐Yes	☐No	☐Yes	☐No

	Yourself		Family Member	
Respiratory:				
Asthma	☐Yes	☐No	☐Yes	☐No
Bronchitis	☐Yes	☐No	☐Yes	☐No
COPD	☐Yes	☐No	☐Yes	☐No
Emphysema	☐Yes	☐No	☐Yes	☐No
Pneumonia	☐Yes	☐No	☐Yes	☐No
Tuberculosis	☐Yes	☐No	☐Yes	☐No
Cardiovascular:				
Heart Disease	☐Yes	☐No	☐Yes	☐No
Heart Block	☐Yes	☐No	☐Yes	☐No
Heart Attack	☐Yes	☐No	☐Yes	☐No
High Blood Pressure	☐Yes	☐No	☐Yes	☐No
High Cholesterol	☐Yes	☐No	☐Yes	☐No
Stroke	☐Yes	☐No	☐Yes	☐No
Pacemaker	☐Yes	☐No	☐Yes	☐No
Bleeding Disorder	☐Yes	☐No	☐Yes	☐No
Anemia	☐Yes	☐No	☐Yes	☐No
Gastro-Intestinal:				
Hepatitis	☐Yes	☐No	☐Yes	☐No
Hernia	☐Yes	☐No	☐Yes	☐No
Kidney Disease	☐Yes	☐No	☐Yes	☐No
Liver Disease	☐Yes	☐No	☐Yes	☐No
Chron's Disease	☐Yes	☐No	☐Yes	☐No
Colitis / Bowel Disease	☐Yes	☐No	☐Yes	☐No
Ulcer or GERD	☐Yes	☐No	☐Yes	☐No
Genito-Urinary:				
Venereal Disease	☐Yes	☐No	☐Yes	☐No
AIDS	☐Yes	☐No	☐Yes	☐No
HIV+	☐Yes	☐No	☐Yes	☐No
Herpes	☐Yes	☐No	☐Yes	☐No
Musculo-Skeletal:				
Osteo Arthritis	☐Yes	☐No	☐Yes	☐No
Rheumatoid Arthritis	☐Yes	☐No	☐Yes	☐No
Myasthenia Gravis	☐Yes	☐No	☐Yes	☐No
Bells Palsy	☐Yes	☐No	☐Yes	☐No

Are you Pregnant ☐Yes ☐No

Do you use Tobacco? ☐Yes ☐No ☐Occasionally

Do you drink alcohol? ☐Yes ☐No ☐Occasionally

Do you use any Eye Drops? ☐Yes ☐No If Yes, Please List:

_____

_____

Medications List all current prescription & over the counter medications:

_____

_____

_____

_____

_____

Allergic Medications:

_____

_____