

Welcome to Our Office!

Date: _____ Patient's SS#: _____ Birthdate: _____ Age: _____

Patient's full name _____ Sex: M/ F

Mailing Address: _____

City/State/Zip: _____ Home Phone: _____

Name of Employer _____ Work Phone: _____

Name of spouse (or parent if patient is a minor): _____

Person Responsible for Account: _____ Birthdate: _____

Address of person responsible: _____ SS#: _____

Insurance Information:

Vision Insurance Company: _____ ID/Group#: _____

Name of Policyholder (if other than self): _____ Birthdate of Policyholder: _____

Major Medical Insurance: _____ Group #: _____

ID#: _____ Name of Policyholder (if other than self): _____

Birthdate of Policyholder: _____ Address of Policyholder: _____

2nd Medical Insurance (include same info as above): _____

Primary Care Physician: _____ Approx date of last gen health exam: _____

General Health Information (Review of Systems):

Please any that apply to you

- | | | |
|---|---|---|
| <input type="checkbox"/> Allergy/ Immunologic | <input type="checkbox"/> Ear-Nose-Mouth-Throat | <input type="checkbox"/> Respiratory (asthma, COPD, bronchitis) |
| <input type="checkbox"/> Urinary Problems | <input type="checkbox"/> Neurological (nervous, MS, epilepsy) | <input type="checkbox"/> Muscles-Bones-Joints (arthritis) |
| <input type="checkbox"/> Psychiatric (Depression, Bipolar) | <input type="checkbox"/> Endocrine (Thyroid, Diabetes) | <input type="checkbox"/> Blood/ Lymph (anemia) |
| <input type="checkbox"/> Gastrointestinal (ulcers, colitis) | <input type="checkbox"/> Cardiovascular (high blood pressure, stroke) | <input type="checkbox"/> Skin (rosacea, eczema) |

Please list any medications that you are taking (including birth control): _____

Allergies to medications: _____

Family and Social Information:

(Do you or anyone in your family have a history of? all that apply.)

- | | | | |
|---------------------|---|----------------------|---|
| Glaucoma | <input type="checkbox"/> self <input type="checkbox"/> relative | Cataract | <input type="checkbox"/> self <input type="checkbox"/> relative |
| Cancer | <input type="checkbox"/> self <input type="checkbox"/> relative | Macular Degeneration | <input type="checkbox"/> self <input type="checkbox"/> relative |
| Diabetes | <input type="checkbox"/> self <input type="checkbox"/> relative | Eye Surgery | <input type="checkbox"/> self <input type="checkbox"/> relative |
| High Blood Pressure | <input type="checkbox"/> self <input type="checkbox"/> relative | Amblyopia (Lazy eye) | <input type="checkbox"/> self <input type="checkbox"/> relative |
| Headaches | <input type="checkbox"/> self <input type="checkbox"/> relative | Illegal Drug Use | <input type="checkbox"/> self <input type="checkbox"/> relative |
| Smoke | <input type="checkbox"/> self <input type="checkbox"/> relative | Alcohol | <input type="checkbox"/> self <input type="checkbox"/> relative |
| Eye or Head injury | <input type="checkbox"/> self <input type="checkbox"/> relative | | |

Eye Health History:

Check Eye Symptoms You Experience ():

	Left	Right
Redness	<input type="checkbox"/>	<input type="checkbox"/>
Dry Eye Feeling	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>
Constant Tearing	<input type="checkbox"/>	<input type="checkbox"/>
Occasional Tearing	<input type="checkbox"/>	<input type="checkbox"/>
Watery Eyes.....	<input type="checkbox"/>	<input type="checkbox"/>
Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain or Soreness.....	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection of Eye or Lids.	<input type="checkbox"/>	<input type="checkbox"/>
Sties, Chalazion	<input type="checkbox"/>	<input type="checkbox"/>
Fluctuating Visual Acuity.....	<input type="checkbox"/>	<input type="checkbox"/>
"Tired" Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Contact Lens Discomfort.....	<input type="checkbox"/>	<input type="checkbox"/>
Contact Lens Solution Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>

Date of last eye exam: _____

Dr's name: _____

If you wear glasses, when was your first pair prescribed? _____

Do you wear contact lenses? _____

If yes, what kind? _____

Are you interested in Laser Vision Correction? Yes No

Please list any special activities or hobbies: _____

How did you hear about our office?

Payment Policy: (Please Read Carefully)

Payment is due at the time of service. We accept cash, checks, credit card. If you have insurance, we will be happy to bill the estimated portion your insurance plan covers; the remaining balance is due at time of service. When ordering glasses or contacts, half down is required and the balance is due upon delivery.

Signature: _____ **Date:** _____