



**Patient Information**

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email Address \_\_\_\_\_

Patient's Date of Birth \_\_\_\_\_

Occupation \_\_\_\_\_

Name of Employer \_\_\_\_\_

Special visual demands (work or hobbies) \_\_\_\_\_

Please list any members of your household who come to our office \_\_\_\_\_

How did you hear about our office?  Newspaper (list) \_\_\_\_\_  Internet Search

Insurance Listing  Family Member  Yellow Pages  Drive By  Other \_\_\_\_\_

Referred by \_\_\_\_\_ May we send a thank you note?  Y  N

**Insurance Information**

Do you have vision care insurance?  Y  N Name \_\_\_\_\_

I.D. Number \_\_\_\_\_

Do you have health insurance?  Y  N Name \_\_\_\_\_

**Please note:** Insurance may cover none or only part of your fees. If we do not accept direct payment from your insurance plan, you will pay our office at the time of service and submit your receipt for reimbursement from your insurance company. If your insurance does not pay as expected, you are ultimately responsible for all charges. We will be happy to assist you with your claims. Please give any forms to the receptionist. If you are using insurance: I authorize the release of any medical or other information necessary to process this claim.

\_\_\_\_\_  
**Signature of Patient (or Guardian if under 18)**

\_\_\_\_\_  
**Date**





## Health History

Please check the appropriate box if you have had any of the following:

- |  |  |                                   |   |
|--|--|-----------------------------------|---|
| <input type="checkbox"/> Cataracts       | <input type="checkbox"/> Glaucoma      | <input type="checkbox"/> Lazy Eye | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Flashes/Floater | <input type="checkbox"/> Itching       | <input type="checkbox"/> Burning  | <input type="checkbox"/> Dryness              |
| <input type="checkbox"/> Watery Eyes     | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure  |
| <input type="checkbox"/> Allergies       | <input type="checkbox"/> None          |                                   |   |

Do you smoke?  Y  N

List medications you are currently taking \_\_\_\_\_

Are you allergic to any medications?  Y  N List \_\_\_\_\_

### Endocrine

- Thyroid Dysfunction
- Other

### Gastrointestinal

- Crohn's
- Ulcer
- Other

### Integumentary

- Eczema
- Rosacea
- Psoriasis
- Other

### Musculoskeletal

- Fibromyalgia
- Osteoarthritis
- Muscular Dystrophy
- Other

### Neurological

- Multiple Sclerosis
- Epilepsy
- Other

### Psychiatric

- Depression
- Anxiety
- Other

### Respiratory

- Asthma
- Emphysema
- Other

### Any family history of the following:

- Glaucoma
- Macular Degeneration
- Diabetes
- High Blood Pressure