



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 any medications _____

Endocrine

- Thyroid Dysfunction
- Other

No

Gastrointestinal

- Crohn's
- Ulcer
- Other

No

Integumentary

- Eczema
- Rosacea
- Psoriasis
- Other

No

Musculoskeletal

- Fibromyalgia
- Osteoarthritis
- Muscular Dystrophy
- Other

No

Neurological

- Multiple Sclerosis
- Epilepsy
- Other

No

Psychiatric

- Depression
- Anxiety
- Other

No

Respiratory

- Asthma
- Emphysema
- Other

No

Any family history of the following:

- Glaucoma
- Macular Degeneration
- Diabetes
- High Blood Pressure