

PATIENT INFORMATION

First Name: _____ MI: _____
Last Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: () _____ - _____ Work Phone: () _____ - _____
Cell Phone: () _____ - _____
SS# _____ - _____ - _____ Date of Birth: ____/____/____
[] Male [] Female [] Child [] Married [] Single [] Divorced [] Widowed
[] Full-time College Student [] Part-time College Student
Employer: _____
Occupation: _____
Drivers License #: _____ State: _____
Parent or Spouse: _____ Phone: () _____ - _____
Parent or Spouse Place of Business: _____
Referred By: _____

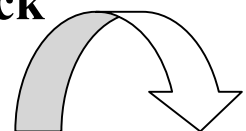
INSURANCE INFORMATION

Vision Insurance Coverage: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Policy Holder's Name: _____
SS# _____ - _____ - _____ Date of Birth: ____/____/____
Relationship to Policy Holder: _____
Policy Holder's Place of Business: _____
Insured ID # _____ Group #: _____
Medical Insurance Coverage: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Policy Holder's Name: _____
SS# _____ - _____ - _____ Date of Birth: ____/____/____
Relationship to Policy Holder: _____
Policy Holder's Place of Business: _____
Insured ID # _____ Group #: _____

I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR DEPENDENTS, I ACKNOWLEDGE AND UNDERSTAND THAT I AM RESPONSIBLE FOR ALL OF THE SERVICES RENDERED TO ME OR ANY MEMBER OF MY FAMILY. I HAVE BEEN NOTIFIED THAT MEDICARE MAY DEEM SOME SERVICES AS NOT MEDICALLY NECESSARY OR ARE NON-COVERED SERVICES BASED ON MEDICARE B GUIDELINES. I ACKNOWLEDGE AND ACCEPT LIABILITY FOR PAYMENT OF THESE SERVICES.

Signature: _____ Date: ____/____/____

More on Back



Medical Eye History

Date of Last Eye Exam: _____ / _____ / _____ By Dr. _____

Have You Ever Worn Glasses? [] Yes [] No
 How Are They Used? [] Distant [] Near [] Constant

Do You Wear Contact Lenses Now? [] Yes [] No
 Type Worn? [] Daily Wear [] Disposable [] Extended Wear [] Astigmatism [] Gas Permeable
 Are You Interested in Contact Lenses? [] Yes [] No

What Is The Reason For Your Visit Today? (Please Check All That Apply.)

- | | | |
|--|--|--|
| <input type="checkbox"/> General Check-Up | <input type="checkbox"/> Problem With Present Contacts | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Lost Or Broken Glasses | <input type="checkbox"/> Eyes Burn Or Itch | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Blurred Distance Vision | <input type="checkbox"/> Pain In The Eyes | <input type="checkbox"/> Lazy Eye |
| <input type="checkbox"/> Blurred Near Vision | <input type="checkbox"/> Flashes Of Light | <input type="checkbox"/> Crossed Eye |
| <input type="checkbox"/> Poor Night Vision | <input type="checkbox"/> Spots Or Floaters | <input type="checkbox"/> Color Vision Problems |
| <input type="checkbox"/> Other (explain) _____ | | |

Do You or Any Family Member Have . . .

	<u>SELF</u>	<u>FAMILY</u>
Glaucoma.....	[] Yes [] No	[] Yes [] No _____
Cataracts.....	[] Yes [] No	[] Yes [] No _____
Diabetes.....	[] Yes [] No	[] Yes [] No _____
Migraine Headaches.....	[] Yes [] No	[] Yes [] No _____
Retinal Detachments.....	[] Yes [] No	[] Yes [] No _____
Macula Degeneration.....	[] Yes [] No	[] Yes [] No _____
Heart Trouble.....	[] Yes [] No	[] Yes [] No _____
High Blood Pressure.....	[] Yes [] No	[] Yes [] No _____
Other Illnesses or Surgeries:	_____	

Do You Have Any Problems With Any Of These Systems? (Please Circle)

- | | | | |
|----------------|-------------------|------------------|-------------------|
| Cardiovascular | Endocrine(Glands) | Allergic/Immune | Ear/Nose/Throat |
| Respiratory | Blood/Lymph | Gastrointestinal | Musculoskeletal |
| Nervous | Mental | Genitourinary | Integument (Skin) |

Do You Use Any Of The Following: (Please Circle) Cigarettes/Tobacco Alcohol Social Drugs

Have You Had Any Eye Surgery, Eye Injury or Eye Infections? If So, Give Type And Date:

Are You Allergic To Any Medications? [] Yes [] No

If So, Please List: _____

Please List All Medications You Are Currently Taking: _____
