Welcome to Our Office!

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

Patient's full name_____ **Sex:** M/ F

Mailing Address:_____

City/State/Zip:_____ **Home Phone:**_____

EMAIL ADDRESS:_____ **CELL 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

□Allergy/ Immunologic □Ear-Nose-Mouth-Throat □Respiratory (asthma, COPD, bronchitis)

□Urinary Problems □Neurological (nervous, MS, epilepsy) □Muscles-Bones-Joints (arthritis)

□Psychiatric (Depression, Bipolar) □Endocrine (Thyroid, Diabetes) □Blood/ Lymph (anemia)

□Gastrointestinal (ulcers, colitis) □Cardiovascular (high blood pressure, stroke) □ 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	□self □relative	Cataract	□self □relative
Cancer	□self □relative	Macular Degeneration	□self □relative
Diabetes	□self □relative	Eye Surgery	□self □relative
High Blood Pressure	□self □relative	Amblyopia (Lazy eye)	□self □relative
Headaches	□self □relative	Illegal Drug Use	□self □relative
Smoke	□self □relative	Alcohol	□self □relative
Eye or Head injury	□self □relative		

Eye Health History:

Check Eye Symptoms You Experience (☑):

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

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:_____