PATIENT INFORMATION

GENERAL INFORMATION

First Name: M.I.: Last Name: Preferred (*nickname*):

Date of Birth: Male / Female Patient Social Security Number:

Street Address: City: State: Zip:

Phone (*cell* | *hm.* | *wrk.*): Phone (*cell* | *hm.* | *wrk.*): Phone (*cell* | *hm.* | *wrk.*):

Email: Preferred Contact Method: *cell phone* | *email* | *text* | *other*

Patient: *employed* | *retired* | *student* Marital Status of Patient: m*arried* | *single* | d*ivorced* | w*idowed*

Name of Employer/School: Occupation:

Emergency Contact Person (*phone & relationship to patient*):

How Were You Referred to Our Office?:

RESPONSIBLE BILLING PARTY

Name of Responsible Billing Party of Account: Relationship to Patient:

Street Address: City: State: Zip:

Phone Number: E-Mail:

RESPONSIBLE BILLING PARTY

I, _____ **understand that I *am responsible for any balances not covered***
(Printed Name of Responsible)
by insurance/copays & agree to pay copays at the time of service. I agree to pay balances not covered by insurance upon receipt of statement.

X

Signature of Responsible Date

INSURANCE INFORMATION *(If you have secondary medical insurance, please list primary first & secondary second)*

Vision Insurance Company: Vision Insurance Member Name:

Vision Insurance Member D.O.B: Vision Insurance Member SSN :

Primary Medical Insurance: Primary Member Name:

Primary Medical Member D.O.B: Primary Medical Member SSN:

Group/Policy #: ID #:

Do You Have Any Copays For This Insurance? *yes* | *no* | *unsure* If ***YES***, Copay Amount:

PATIENT INFORMATION

EYE HISTORY

Date of Last Eye Exam: Date of Last Eye Dilation:

Currently Wear Glasses? *Yes | No* Currently Wear Contacts? *Yes | No* Interested in Contacts? *Yes | No*

Any Concerns For This Visit?:

MEDICAL HISTORY

Have you or a family member experienced (or been treated) for any of the following? *Circle all that apply.*

Allergies	*Yes | No | Family*
Arthritis	*Yes | No | Family*
Asthma	*Yes | No | Family*
Blood | Lymph Disorder	*Yes | No | Family*
Cancer	*Yes | No | Family*
Diabetes	*Yes | No | Family*
Heart Disease	*Yes | No | Family*
High Blood Pressure	*Yes | No | Family*
High Cholesterol	*Yes | No | Family*
Kidney Disease	*Yes | No | Family*
Lupus	*Yes | No | Family*
Neurological Conditions	*Yes | No | Family*
Psychiatric Disorder	*Yes | No | Family*
Seizures	*Yes | No | Family*
Sexually Transmitted Disease	*Yes | No | Family*
Stroke	*Yes | No | Family*
Thyroid Dysfunction	*Yes | No | Family*

Current Medications (*Prescriptions, Over-the-Counter & Dosage*):

Allergies *(Including Drug)*:

Height: **Weight:**

Are you pregnant or nursing?	*Yes | No*
Do you (have you) use tobacco?	*Yes | No* **Quit Year:**
Do you drink alcohol?	*Yes | No | Socially*
Do you use illegal drugs?	*Yes | No*

Have you or a family member been treated any of the following? *Circle all that apply.*

Cataracts	*Yes | No | Family*
Crossed Eye	*Yes | No | Family*
Eye Surgery	*Yes | No | Family*
Eye Turn	*Yes | No | Family*
Glaucoma	*Yes | No | Family*
LASIK or RK	*Yes | No | Family*
Macular Degenration	*Yes | No | Family*
Retinal Detachment	*Yes | No | Family*

Are you currently experiencing (or experienced) any of the following? *Circle all that apply*

Blurry Vision	*Yes | No*
Burning | Itching | Redness	*Yes | No*
Dryness	*Yes | No*
Discharge	*Yes | No*
Double Vision	*Yes | No*
Excessive Tearing | Watering	*Yes | No*
Eye Infection	*Yes | No*
Eye Pain | Soreness	*Yes | No*
Floaters | Spots	*Yes | No*
Halos	*Yes | No*
Headaches	*Yes | No*
Light Flashes	*Yes | No*
Light Sensitivity	*Yes | No*