WELCOME TO OUR OFFICE!

Thank you for choosing our practice for your eye care needs. So that we may better care for you, please fill out the following information. If you have any questions or concerns, please do not hesitate to ask for assistance. We will be happy to help! All responses will be kept in strictest confidence.

Patient's Name: _____ _____ _____ Date: _____
PATIENT'S FIRST MI LAST

SSN: _____ ☐ Male ☐ Female Birthdate: _______________ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ E-Mail Address: _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widow\Widower

Patient's Employer or School: _____ Occupation or Grade: _____

Business Address: _____ Work Phone: _____

Person To Contact In Case Of Emergency: _____ Phone # : _____

Whom May We Thank For Referring You To Us? _____

RESPONSIBLE PARTY

☐ Same as above

Name Of Person Responsible For This Account: _____

Relationship To Patient: _____ SSN: _____ Phone # : _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Work Phone # : _____

INSURANCE INFORMATION

☐ Same as above

Name Of Insured: _____ Relationship To Patient: _____

Birthdate: _______________ Insured's Social Security Number: _____

Name Of Employer: _____

Insurance Company: _____ ID/Group #: _____

I hereby authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eyecare to third party payers and\or health practitioners. I authorize the use of this signature on all insurance submissions. I understand that my eyecare insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.
Our office honors Cash, Check, Discover, Visa, and Mastercard as payment. All fees are payable at the time of service.

I have read and agree to all the provisions of the office financial policy.

Signature of patient (or parent if minor): _____ Date: _____

MEDICAL HISTORY FORM

Patient Name: _____ **Today's Date:** _______________
The information in this confidential personal history form is critical to the evaluation of your visual system.

Family Physician's Name: _____ **Date of last visit:** _______________

Reason for today's visit: _____
Are you interested in purchasing new glasses today? Yes . . . .No
Are you interested in contact lenses? Yes . . . No

Review of Systems: Please indicate any current or past PERSONAL history below: Check √ all that apply

Constitutional
___Good general health lately
___Developmental disability
___Cancer (Type:_____)

Ears/Nose/Mouth/Throat
___Sinusitis
___Dry mouth or throat

Neurological
___Multiple Sclerosis (MS)
___Tumor
___Migraine

Psychiatric
___Depression
___Attention deficit (ADD)

Cardiovascular
___Heart Disease
___Hypertension/Blood pressure
___Stroke/CVA

Respiratory
___COPD (chronic obstruction)
___Sleep Apnea
___Asthma

Gastrointestinal
___Crohn's

Genitourinary
___BPH(prostate)
___Currently pregnant
___Currently nursing

Endocrine
___Type 2 Diabetes
___Type 1 Diabetes
___Thyroid dysfunction

Hematologic/Lymphatic
___High Cholesterol
___Anemia

Allergy/Immune
___Rheumatoid Arthritis
___Sjogrens Syndrome

Integumentary
___Herpes simplex/cold sores
___Rosacea
___Herpes zoster/shingles

Past Ocular History
___Cataract
___Macular degeneration
___Eye surgery
___Patching
___Stabismus(turned eye)
___Amblyopia(lazy eye)
___Dry eye
___Injury
___Glaucoma suspect
___Glaucoma

List Allergies (Both drug and environmental)_____

_____

Smoking Status: Please Check √ the most appropriate response
___Never Smoker
___Previous Smoker
___Current smoker occasional
___Current smoker every day

List Medications You Are Taking (Include Non-prescription)_____

_____

_____

Please indicate FAMILY history: Circle Yes or No; If Yes, write in father, mother, brother, sister, son or daughter

☐ Medical
Cancer . . . . . No Yes_____
Diabetes . . . . . No Yes_____
Hypertension. . . . . No Yes_____

☐ Ocular
Cataract . . . . . No Yes_____
Macular degeneration . . No Yes_____
Glaucoma . . . . . No Yes_____