WELCOME

Patient Information

Thank you for choosing our practice for your eyecare needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name _____ Date _____ Driver's License#_____
First Middle Initial Last

Address _____ City _____ State _____ Zip _____

Birthdate _____ E-mail _____

Home Phone (_____)_____ Cell Phone (_____)_____ Work Phone (_____)_____

Do you prefer to receive calls at: ❑ Home ❑ Work ❑ Cell ❑ No Preference

❑ Married ❑ Widowed ❑ Single ❑ Minor ❑ Separated ❑ Divorced ❑ Partnered for_____years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ City _____ State ____ Zip _____

Spouse or parent's name _____ Employer _____ Work Phone (_____) _____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency _____ Phone (_____)_____

Responsible Party

Name of person responsible for this account _____

Relationship to patient _____ Phone (_____)_____

Address _____ City _____ State _____ Zip _____

Name of employer _____ Work Phone (_____)_____

Insurance Information

Name of insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____ Date employed _____

Name of employer _____ Work Phone (_____) _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Member ID# _____ Group# _____

Insurance Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

DO YOU HAVE A 2ND INSURANCE/VISION PLAN ❑ No ❑ Yes IF YES COMPLETE THE FOLLOWING:

Name of insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____ Date employed _____

Name of employer _____ Work Phone (_____) _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Member ID# _____ Group# _____

Insurance Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

CONFIDENTIAL

Health History

Name of PCP(MD, PA, NP) _____ Phone _____

Reason for today's exam _____

Date of last exam _____ Name of eye doctor _____

Do you or anyone in your immediate family have a history of the following?

- ❑ Diabetes ❑ Blindness ❑ High blood pressure
- ❑ Cataracts ❑ Thyroid ❑ Turned or lazy eye
- ❑ Glaucoma ❑ Heart condition ❑ Pulmonary

Please check any of the following conditions that apply to you:

- ❑ Frequent headaches ❑ Drug allergies ❑ Pregnant /Nursing
- ❑ Allergies ❑ Sinus trouble ❑ Have given birth in the last 6 months

Please list all medications you are currently taking: _____

Have you ever had any of the following conditions involving your eyes?

- ❑ Eye surgery ❑ Sensitivity to light ❑ Eye infection or disease
- ❑ Eye injury ❑ Floaters or spots ❑ Double vision
- ❑ Medical treatment ❑ Poor distance vision ❑ Eye strain
- ❑ Severe pain ❑ Poor near vision ❑ Eyes burn, itch, or water

Do you currently wear glasses? ❑ Yes ❑ No

When do you wear your glasses?

- ❑ All the time ❑ Reading/near work
- ❑ Work safety ❑ Distance tasks only
- ❑ Computer work ❑ Other, please explain _____

Have you ever worn contacts? ❑ Yes ❑ No

Are you interested in wearing contact lenses? ❑ Yes ❑ No

If so, what style?

- ❑ Soft ❑ Extended Wear ❑ Gas Permeable ❑ Bifocal
- ❑ Tinted ❑ Astigmatic ❑ Disposable ❑ Unsure

Do you work at a computer or video display terminal? ❑ Yes ❑ No How many hours a day? ____

What hobbies or sports do you participate in? _____

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient