PATIENT INFORMATION

DATE | LAST NAME | FIRST NAME | MI

SS# | AGE | DOB | ADDRESS

CITY/STATE | ZIP | HOME PHONE | WORK PHONE

CELL PHONE | EMAIL

OCCUPATION | EMPLOYER/SCHOOL

EMERGENCY CONTACT | TELEPHONE | RELATIONSHIP

How did you hear about us? ◯ Insurance List ◯ Phonebook ◯ Internet ◯ Newspaper ◯ Patient Referral

Who may we thank for telling you about our office? _____

Are you involved in any of the following activities? (please check all that apply):

◯ Driving/Travel ◯ Computer/Laptop ◯ Reading ◯ Art ◯ Golf ◯ Swimming ◯ Welding/Woodworking
◯ Arts and craft ◯ Biking ◯ Hiking/Running ◯ Fishing ◯ Skiing/Snowboarding ◯ Sewing/Needlework
◯ Musical Instruments ◯ Hunting ◯ Motorcycles ◯ Other _____

MEDICAL HISTORY

Do you have any of the following medical conditions? (Mark inside the circle)

◯ Diabetes Type:_____ Date of diagnosis_____ ◯ High Blood Pressure ◯ Headaches

◯ Allergies List:_____ ◯ Other Health Problems_____

◯ Current Medications_____

Smoking: Yes ◯ No ◯ How often?_____ Do you drink alcohol? Yes ◯ No ◯ How often?_____

Name of family/primary doctor_____ Date of last visit_____

OCULAR HISTORY

Do you or anyone in your family have the following? (please indicate family member)

● Macular Degeneration: Yes ◯ No ◯ _____ ● Glaucoma: Yes ◯ No ◯ _____

● Retinal Detachment: Yes ◯ No ◯ _____ ● Cataracts: Yes ◯ No ◯ _____

Other eye condition(s) _____

◯ Eye operation Type:_____Date:_____ ◯ Dry eyes ◯ Contact lenses

◯ Eye injuries Type:_____Date:_____ ◯ Blurry Vision ◯ Do you wear glasses

Date of last eye exam _____ Were your eyes dilated Yes ◯ No ◯

INSURANCE INFORMATION

Vision Insurance _____ Primary Member's Name _____

ID#_____ Primary DOB_____ Person responsible for payment_____

Medical Insurance _____

I, the undersigned, hereby authorize the realease of all information necessary to secure payment of insurance benefits, and the use of this signature on all claim submissions. I am aware of my right to privacy regarding transfer of personal information for insurance purposes and medical care (copies of HIPAA Privacy Notice are available at the front desk)

_____ _____ Update: _____ _____

Patient signature or Legal Guardian | Date | Signature | Date

Update: _____ _____

Signature | Date

For Office Use Only:
Dr.'s Initials_____