

Patient Information

Today's Date _____ SS# _____ DOB _____ Age _____
Last Name _____ First Name _____ MI _____
Address _____ City/State _____ Zip _____
Telephone #'s (Hm) _____ (Wk) _____ (Cell) _____
Email Address _____
Employer/School _____ Occupation _____
Emergency Contact _____ Telephone # _____ Relationship _____
How did you hear about us? __ Insurance List __ Internet __ Phonebook __ Newspaper __ Patient Referral
Whom may we thank for telling you about our office? _____

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

___ Art ___ Arts & Crafts ___ Sewing/Needlework/Bead Work ___ Biking ___ Hiking/Running
___ Hunting ___ Fishing ___ Golf ___ Skiing/Snowboarding ___ Swimming ___ Welding/Woodworking
___ Driving/Travel ___ Motorcycles ___ Computer/Laptop ___ Reading ___ Musical Instruments

Medical History

Diabetes __ Yes __ No Type _____ Date of diagnosis _____ High Blood Pressure __ Yes __ No
Allergies __ Yes __ No List _____ Headaches __ Yes __ No
Other health problems _____
Current medications _____
Do you use (cigarettes/tobacco) __ Yes __ No How Much _____ (alcohol) __ Yes __ No
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 _____ Retinal Detachment _____
Glaucoma _____ Cataracts _____
Other eye condition(s) _____
Have you ever had any eye operations __ Yes __ No If yes, what type _____ Date _____
Have you ever had any eye injuries __ Yes __ No If yes, what type _____ Date _____
Do you have dry eyes __ Yes __ No Blurry vision __ Yes __ No
Do you wear glasses __ Yes __ No Contact Lenses __ Yes __ No
Date of last eye exam _____ Were your eyes dilated __ Yes __ No

Vision Insurance _____ Primary Member's Name _____
ID# _____ Primary DOB _____ Person responsible for payment _____
Medical Insurance _____

I, the undersigned, hereby authorize the release 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).

Patient signature or Legal Guardian

For Office Use Only:
Dr.'s Initials _____