PRINT PLEASE

PATIENT INFORMATION

Last Name _____ First Name & Initial _____ Sex: ☐ M ☐ F

Address _____ City _____State _____ Zip_____

Date of Birth _____ Birth State _____ Mother's Maiden Name _____

Does patient live at a nursing home? Yes ☐ No ☐ If yes, name of facility: _____

Race: ☐ Black/African American ☐ White ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Other

Ethnicity: ☐ Unknown ☐ Not Hispanic/Not Latino ☐ Hispanic/Latino Special Needs _____

Patient's SS# _____ E-mail _____

Primary Phone _____ Secondary Phone _____ Cell Phone _____

Primary Language Spoken _____

Patient's Employer _____ Occupation _____

Preference of Communication: ☐ Phone ☐ US Mail ☐ E-mail ☐ Text Cell Phone Carrier _____

Referred By _____ Phone _____
(Give Name & Address)

☐ Doctor ☐ Optometrist ☐ Existing Patient ☐ Family Member ☐ Co-Worker ☐ Friend ☐ Insurance ☐ Internet ☐ Other

Primary Care Physician _____ Phone _____

Pharmacy _____Location _____ Pharmacy Phone _____

Emergency Contact _____ Contact's Phone _____
(Give Name)

Will allow release of my medical information to _____

INSURANCE

Vision _____ Medical (Primary) _____ Medical (Secondary)_____

Name of primary insured _____ Date of Birth _____ SS# _____

Not sure of your insurance coverage? Please call the TOLL FREE NUMBER on the back of your insurance card.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: *I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his services as described, realizing I am responsible to pay all non-covered services.*

AUTHORIZATION TO RELEASE INFORMATION: *I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.*

Signature _____ Date _____/_____/_____

Please continue to back of this page.

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MEDICAL INFORMATION

Patient Name _____

OCULAR MEDICAL HISTORY

Glaucoma	Yes ☐ No ☐	Crossed Eyes	Yes ☐ No ☐	Blurred Vision	Yes ☐ No ☐
Cataracts	Yes ☐ No ☐	Lazy Eye	Yes ☐ No ☐	Double Vision	Yes ☐ No ☐
ARMD	Yes ☐ No ☐	Diabetes	Yes ☐ No ☐	Floaters	Yes ☐ No ☐
Eye Injury	Yes ☐ No ☐	Dry Eyes	Yes ☐ No ☐	Tearing	Yes ☐ No ☐
Retinal Disease	Yes ☐ No ☐	Refractive	Yes ☐ No ☐	Eye Discharge	Yes ☐ No ☐
Blindness	Yes ☐ No ☐	Eyelid Problem	Yes ☐ No ☐		

Do you wear contacts? Yes ☐ No ☐ If yes, what kind? _____

OCULAR SURGICAL HISTORY

Please list **ALL** previous eye surgeries: _____

_____

FAMILY EYE HISTORY

Does any family member have eye disease? Yes ☐ No ☐ If yes, explain: _____

_____

SOCIAL HISTORY

Do you drink alcohol? Yes ☐ No ☐ Do you smoke? Yes ☐ No ☐

MEDICAL HISTORY

Diabetes	Yes ☐ No ☐	Ulcers/Digestive	Yes ☐ No ☐	Allergies	Yes ☐ No ☐
Hypertension	Yes ☐ No ☐	Kidney Disease	Yes ☐ No ☐	Arthritis	Yes ☐ No ☐
Heart Disease	Yes ☐ No ☐	Neurological	Yes ☐ No ☐	Headaches	Yes ☐ No ☐
Ear/Nose/Throat	Yes ☐ No ☐	Psychiatric	Yes ☐ No ☐	Are you pregnant?	Yes ☐ No ☐
Lung Disease	Yes ☐ No ☐	Cancer	Yes ☐ No ☐		

MEDICATIONS

Please list names of **ALL** medications that you are currently taking: _____

_____

Please list names of **ALL** medications that you are allergic to: _____

_____

Signature _____ Date _____/_____/_____

Reviewed & Updated _____ Date _____/_____/_____