PATIENT INFORMATION **PRINT PLEASE**

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: _____

Special Needs: ☐ Hearing Impaired ☐ Wheelchair ☐ Translator ☐ Other _____

Race: (*circle*) Black/African American White American Indian/Alaska Native Asian Native Hawaiian/Pacific Islander Other

Ethnicity: (*circle*) Unknown Not Hispanic/Not Latino Hispanic/Latino

Patient's SS# _____ E-mail _____

Primary Phone _____ Secondary Phone _____ Cell Phone _____

Primary Language Spoken _____

Patient's Employer ___ _____ Occupation _____

Referred By _____ Phone _____
(Give Name & Address)

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

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.*

☐ HIPAA compliance information has been made available to me.

Signature _____ Date _____/_____/_____

COMPLETE & GIVE TO FRONT DESK

MEDICAL HISTORY

PRINT PLEASE

Patient Name _____ DOB _____

Primary Care Physician _____ Phone _____

Specialist _____ Phone _____

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 ☐
Macular Degeneration	Yes ☐ No ☐	Diabetes	Yes ☐ No ☐	Floaters	Yes ☐ No ☐
Eye Injury	Yes ☐ No ☐	Dry Eyes	Yes ☐ No ☐	Tearing	Yes ☐ No ☐
Retinal Disease	Yes ☐ No ☐	Eyelid Problem	Yes ☐ No ☐	Eye Discharge	Yes ☐ No ☐
Blindness	Yes ☐ No ☐	Droopy Eyelid	Yes ☐ No ☐		

Do you wear glasses? Yes ☐ No ☐
Do you wear contacts? Yes ☐ No ☐ If Yes, what kind? _____
If Yes to glasses/contacts, are you interested in a Free Lasik Evaluation? Yes ☐ No ☐
Have you had Lasik? Yes ☐ No ☐

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 currently use tobacco products? Yes ☐ No ☐ Do you have a history of tobacco use? Yes ☐ No ☐
Do you drink alcohol? Yes ☐ No ☐ Social ☐

MEDICAL HISTORY

Type 1 Diabetes	Yes ☐ No ☐	Heart Disease	Yes ☐ No ☐	Thyroid	Yes ☐ No ☐
Yes? Last AIC reading	_____	History of Stroke	Yes ☐ No ☐	Allergies	Yes ☐ No ☐
Blood sugar reading	_____	Ear/Nose/Throat	Yes ☐ No ☐	Arthritis	Yes ☐ No ☐
Type 2 Diabetes	Yes ☐ No ☐	Lung Disease	Yes ☐ No ☐	Headaches	Yes ☐ No ☐
Yes? Last AIC reading	_____	Ulcers/Digestive	Yes ☐ No ☐	HIV/AIDS	Yes ☐ No ☐
Blood sugar reading	_____	Kidney Disease	Yes ☐ No ☐	Hepatitis C	Yes ☐ No ☐
Flu Shot	_____	Neurological	Yes ☐ No ☐	Autoimmune	Yes ☐ No ☐
Pneumovax Shot	_____	Psychiatric	Yes ☐ No ☐	Specify	_____
Hypertension (High BP)	Yes ☐ No ☐	Cancer	Yes ☐ No ☐	Are you pregnant?	Yes ☐ No ☐

MEDICATIONS

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

_____

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

_____

Patient Signature _____ Date _____

COMPLETE & GIVE TO TECHNICIAN