PATIENT INFORMATION AND HISTORY

First Name ______________________ MI____ Last Name ______________________

☐Mr. ☐Mrs. ☐Miss ☐Ms. ☐Male ☐Female Nickname__________ Date of Birth______________

Address______________________ City/State______________ Zip__________

Home Phone ______________ Alt. Phone ______________ SS# ______________

☐Married ☐Single ☐Other ☐Full Time Student ☐Part Time Student Spouse/Parent______________

Employer ______________ Occupation ______________ Email Address______________

How were you referred to our office? ☐Phone Book ☐Insurance List ☐Advertisement ☐Drive By

☐ Patient ______________________ ☐ Doctor ______________________

PRIMARY INSURANCE INFORMATION

Vision Insurance __________ ID #______________ Member's Name ______________

Member's Date of Birth______________ Relationship to Patient ☐Self ☐Spouse ☐Child ☐Other

Medical Insurance __________ ID #______________ Member's Name ______________

Member's Date of Birth______________ Relationship to Patient ☐Self ☐Spouse ☐Child ☐Other

VISUAL HISTORY

Last Eye Examination __________

Do you wear glasses? ☐Yes ☐No For how long?_____ Do you wear contacts? ☐Yes ☐No For how long?_____

Have you had ☐Lasik Surgery When ?________ ☐Eye Surgery When? ______ ☐Eye Injury When? ______

SOCIAL HISTORY

Tobacco? ☐Yes ☐No Alcohol? ☐Yes ☐No ☐Occ. Narcotics? ☐None ☐Recreational ☐Clinically dependent

MEDICAL HISTORY

General Health ________ Family Doctor ______________________

Current Medications ____

____

Allergies ☐Yes ☐No List (including medications)______________________

History	Personal	Family	History	Personal	Family	History	Personal	Family
Arthritis	Y N	Y N	Nervousness	Y N	Y N	Hepatitis	Y N	Y N
Asthma	Y N	Y N	Thyroid Disease	Y N	Y N	Cancer	Y N	Y N
Respiratory	Y N	Y N	Headaches	Y N	Y N	Stroke	Y N	Y N
Heart Attack	Y N	Y N	High Blood Pressure	Y N	Y N	Herpes	Y N	Y N
Diabetes	Y N	Y N	Flashes or Floaters	Y N	Y N	HIV	Y N	Y N
Glaucoma	Y N	Y N	Retinal Detachment	Y N	Y N	Cataracts	Y N	Y N
Renal Disease	Y N	Y N	Macular Degeneration	Y N	Y N	Dry Eyes	Y N	Y N

I certify that all information given by me is true. I authorize all routine or emergency vision care and services provided by this office and understand that I may withdraw my consent at any time.

Signature ______________ ______________ Date______________

INSURANCE SIGNATURE ON FILE: I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefit, and I authorize payment of these benefits directly to my doctor on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release the Centers for Medicare and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in item 9 of the CMS-1500 claim form or electrically submitted claim) my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor as my agent above. I will be responsible for co-payments and payments for non-covered services.

Signature ______________________________ Date______________