DR. LANDRIO & ASSOCIATES

Name: _____

Address: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email: _____

Preferred Communication? Home Work Cell Text E-Mail

Occupation: _____

Gender: Male Female Marital Status: _____

Age: _____ Date of Birth: _____Ethnicity_____

SS#: _____-_____-_____ Language_____

Emergency Contact Name _____

Primary Care Physician Name_____

Pharmacy Name and # _____

REFERRED BY: _____

Insurance Information

What is your primary medical insurance?

Insurance Name: _____

Subscriber: _____

Subscriber DOB: _____

Relationship to Patient: _____

ID#: _____

Copay Amount: $_____ Referral Needed? YES or NO

What is your secondary medical insurance?

Insurance Name: _____

Subscriber: _____

Subscriber DOB: _____

Relationship to Patient:_____

ID#: _____

Copay Amount: $_____ Referral Needed? YES or NO

Do you have vision / eyeglass / contact lens coverage?

Plan Name: _____

Subscriber: _____

Relationship to Patient: _____

ID#_____

Medical History

Do you have high blood pressure? YES NO Since what yr?_____

Do you have diabetes? YES NO Since what year? _____

Do you have high cholesterol? YES NO Since what year? _____

Cardiovascular: YES NO _____

Endocrine/Thyroid: YES NO_____

Gastrointestinal: YES NO_____

Respiratory: YES NO_____

Musculoskeletal: YES NO_____

Neurological: YES NO_____

Other: _____

Medications: (including over the counter): _____

_____

Allergies: YES NO SPECIFICALLY ALLERGIC TO:

_____

Do you smoke: YES NO FORMER SMOKER

Ocular History

Do you currently have or ever had any eye diseases, eye injuries, eye surgery, dry eyes, double vision, or any problems with your eyes? Please describe: _____

_____

_____

Do you wear glasses? YES NO Do you wear contacts? _____

Type of contacts: _____ If no, are you interested? Y/N

Is there a family history of glaucoma, diabetes, high blood pressure or any other disease that runs in your family? Please describe:

_____

_____

SIGNATURE ON FILE

I authorize DR. LORI LANDRIO, OD, PLLC to use this authorization instead of my actual signature on my insurance submissions. I authorize the release of information to my insurance companies. I authorize payment directly to DR. LORI LANDRIO, OD, PLLC when applicable. I understand I am responsible for payment of any charges for all services not covered by insurance companies. I understand that all co-payments must be paid in full on day of services rendered. I have received a copy of the HIPAA polices.

Signature: _____Date:_____

Relationship (if not patient): _____

PLEASE GIVE US YOUR INSURANCE CARDS SO THEY CAN

BE RECORDED INTO YOUR CHART

REMINDER: ALL REFERRALS MUST BE PRESENTED AT THE TIME OF YOUR EXAM. COPAYS WILL BE COLLECTED ON DAY OF SERVICE.