Welcome to our Office

Name____ Date_________________________

Address____ City/Zip _____________________

Home Phone_____________________ Work Phone_________________________ Cell Phone____________________

E-mail_________________________ Occupation _____________________ Guardian (if under 18)__________________

Birth Date___________________ Social Security #___________________________ Last Eye Exam__________________

Primary Physician____ Dr.'s Phone #__________________

Medical History

Please list any allergies to medications____

Please list your current medications____

Are you pregnant and/or nursing? ___Yes ___No

Do you wear glasses? ___Yes ___No If yes, how old is your current pair? __________________________

Do you wear contacts? ___Yes ___No If yes, how old is your current pair?__________________________

Do you sleep in your contacts? ___Yes ___No Solutions Used____________________________________

Type of contact lenses ___Rigid ___Soft Brand if known_____________________________________

Hours per day spent on computer___________________ Distance from eyes to screen______________

Please note if you or a family member have any of the following conditions:

	Self	Family		Self	Family
Blindness			Diabetes		
Cataract			Heart Disease		
Crossed eyes			High Blood Pressure		
Glaucoma			Kidney Disease		
Macular Degeneration			Lupus		
Retinal Detachment			Thyroid Disease		
Arthritis			Cancer		

Do you drive? ___Yes ___No

Do you use illegal drugs? ___Yes ___No

Do you use tobacco products? ___Yes ___No

Do you use alcohol? ___Yes ___No

Dilation of the pupils with drops helps the doctor diagnose disease and may be required by your insurance. It may cause light sensitivity and blurry near vision. If you postpone dilation, it can be scheduled another day.

___I grant permission for dilation ___I do not grant permission ___Initials

I have read and been offered a copy of the HIPAA compliance policy and understand that my health information will not be used or disclosed without written authorization.

Signature:____ Date:____________________________________

Medical Insurance:____ Insured party:______________________________

Vision Plan:____ Insured party:______________________________

I understand that I am responsible for any fees not paid for by my insurance and copayments are due on the day of service