TELL US A LITTLE ABOUT YOURSELF…

To help our doctor better serve your specific needs, please answer the following questions as they apply to you

PLEASE FILL IN THE BLANKS

______________________________ ______ ______________ ☐ Male ☐ Female
Last Name First Name MI Social Security #

______________________________ __________ __________ __________
Street Address City State Zip

______________ ______________ ______________________ __________
Cell Phone # Secondary Phone # Email (NOT SHARED INFORMATION) Birth Date

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PRIMARY INSURANCE

Insurance Name____

Primary Holder's Name (As shown on card)____________________________________

Primary Holder's Date of Birth____

Member ID Number ____

Employer____

Patient Relationship to Insured Marital Status

☐Self ☐ Spouse ☐Child ☐ Other ☐ Single ☐Married ☐Other

Primary Care Physician

Name___________________________________

Phone______________ Fax_______________

I am aware of the Health Privacy Act (HIPAA) information is available upon request

***Note: Most insurance policies pay only a portion of your total charges. If you have any questions about your coverage, please contact your representative directly. We DO NOT guarantee the accuracy of benefit information given to us by insurance companies.

**I understand that I will be held responsible for the services I will be receiving**. I further understand that payment is due at the time of services. In the event it becomes necessary to assign this account for collections or that any costs are incurred for collection of my past due account, I agree to be responsible for all costs of collection including a reasonable attorney fee. I authorize payment of medical benefits to the physician or supplier for the services rendered.***

Signed: ________________________________ Date: ______________

PATIENT HISTORY AND INFORMATION

What is the main reason for today's exam? ____

When was your last exam? ___________________ Current Medications: _______________________________

Do you have any drug allergies? _______________ If yes, which ones? ________________________________

EYE HISTORY (Mark all that apply)

☐ Glaucoma	☐ Dryness	☐ Sandy or Gritty Feeling
☐ Cataract	☐ Excess Tearing/Watering	☐ Strabismus (Crossed Eyes)
☐ Macular Degeneration	☐ Eye Pain or Soreness	☐ Blurred Vision Near
☐ Retinal Detachment	☐ Foreign Body Sensation	☐ Distorted Vision (Halos)
☐ Color Blindness	☐ Infection of Eye or Lid	☐ Double Vision
☐ Headaches	☐ Itching	☐ Floaters or Spots
☐ Glare/Light Sensitivity	☐ Mucous Discharge	☐ Fluctuating Vision
☐ Tired Eyes	☐ Drooping Eyelid	☐ Loss of Vision
☐ Amblyopia (Lazy Eye)	☐ Redness	☐ Loss of Side Vision
☐ Burning		

GENERAL HEALTH CONDITION (Mark all that apply)

☐ Fever	☐ Gastrointestinal	☐ Endocrine (Thyroid, Diabetes)
☐ Weight Loss	☐ Kidney	☐ Blood/Lymph
☐ Other Symptoms	☐ Muscles, Bones, Joints	☐ Stroke
☐ Ear, Nose, Throat	☐ Skin	☐ Pregnant
☐ High Blood Pressure	☐ Neurological	☐ Nursing
☐ Respiratory (Asthma)	☐ Anxiety or Depression	

FAMILY HISTORY

☐ Amblyopia (Lazy Eye)	☐ Retinal Detachment	☐ High Blood Pressure
☐ Blindness	☐ Strabismus (Eye Turn)	☐ Kidney Disease
☐ Cataract(s)	☐ Arthritis	☐ Lupus
☐ Color Blindness	☐ Cancer	☐ Stroke
☐ Glaucoma	☐ Diabetes	☐ Thyroid Disease
☐ Macular Degeneration	☐ Heart Disease	☐ Other

WORK HISTORY

Current Occupation: ___________________ Employer: ____

Hobbies/Interests:____

GLASSES	CONTACTS
Do you use a computer? Yes No	Have you worn contacts? Yes No
Do you have problems with glare? Yes No	Do you currently wear contacts? Yes No
Any problems with your vision at night? Yes No	Type and Brand: _____________________
Do you wear sunglasses? Yes No	Hours per day: ________________
Do you wear occupation glasses? Yes No	Days per week: _______________
	*If you're not a contact lens wearer, would you be interested? Yes No