Patient Information

Thank you for choosing our office. In order to serve you properly we need the following information. Please print. All information in confidential.

Full Name (Mr./Mrs./Ms./Miss/Dr.) _____

Are you: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Minor (under 18 years old)

Parent's Name if Minor: _____

Address (and Mailing address if different) _____

City _____ State _____ ZIP _____

Home Phone _____ Work Phone _____

Date of Birth _____ Age _____ Social Security Number _____ - ____- _____

Occupation _____Hobbies/Special Interest _____

Email Address (*Print Carefully*) _____

Whom may we thank for referring you to our office?

Purpose of your visit today _____

Date of Last Eye Exam _____ Eye Doctor's Name _____Age of Present Glasses _____

Do you wear Contact Lenses? _____Brand_____Are you interested in Contacts? _____

Personal/Family Doctor's Name _____

Insurance Information

Name of insured_____Relationship to patient _____

Birthdate _____SS#/SIN _____ Date employed _____

Name of Employer _____

Address of Employer _____City _____ State _____Zip_____

Insurance Company _____Group # _____

Personal and Family Health History

	Yourself	Your relatives that have had these problems
High Blood Pressure	Yes ☐ No ☐	_____
Diabetes	Yes ☐ No ☐	_____
Glaucoma (high eye pressure)	Yes ☐ No ☐	_____
Cataracts	Yes ☐ No ☐	_____
Macular degeneration	Yes ☐ No ☐	_____

Do you have frequent headaches? Yes ☐ No ☐ How long have they occurred? _____

Have you had?	Any eye injuries	Yes ☐ No ☐		Crossed eye(s)	Yes ☐ No ☐
	Any eye surgeries	Yes ☐ No ☐		Lazy eye	Yes ☐ No ☐
	Eye infections	Yes ☐ No ☐		Double vision	Yes ☐ No ☐

What are the dates and details of the occurrences regarding the above?

Current Medication History

Please list below **all prescription and over the counter medications** you are now taking and what they are for. Please include any diet or birth control medications.
Check here ☐ if you are not currently taking any medications.

Do you have any drug or other allergies? Yes ☐ No ☐ If Yes, please list:

Review of Systems

Do you have problems with: (Please check all that apply - give details in the space to the right)

Skin	Yes ☐ No ☐	_____
Ear, Nose, Throat and Mouth	Yes ☐ No ☐	_____
Lungs / Breathing (TB)	Yes ☐ No ☐	_____
Heart	Yes ☐ No ☐	_____
Thyroid Disorders	Yes ☐ No ☐	_____
Stomach / GI / Intestinal	Yes ☐ No ☐	_____
Genitals / Kidneys / Bladder	Yes ☐ No ☐	_____
Bones / Joints / Muscles	Yes ☐ No ☐	_____
Psychiatric / Mental Concerns	Yes ☐ No ☐	_____
Neurologic Systems	Yes ☐ No ☐	_____
Lymphatic System	Yes ☐ No ☐	_____
Blood or Bleeding Disorders	Yes ☐ No ☐	_____

Social History: Do you?	Smoke	Yes ☐ No ☐		Drink Alcohol	Yes ☐ No ☐
	Chew Tobacco	Yes ☐ No ☐		Use drugs	Yes ☐ No ☐

Payment is due on the date services are rendered unless prior arrangements have been made.

Authorization & Release

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

Please sign _____ Date _____