PATIENT INFORMATION

Date _____

Name _____

Address _____
(Street) (City) (State) (Zip)

Home Phone _____ Business Phone _____

Date of Birth _____ Age _____ Social Security Number _____

Occupation _____ Place of Employment _____

So that we may thank them, who referred you to our office? _____

Email Address _____

Do you wear glasses? _____

Would you like to discuss laser surgery? _____

Do you currently wear contact lenses? _____ / _____ / _____
(Gas Permeable) (Hard) (Soft)

Would you like to discuss contact lenses? _____

Date of last eye examination _____

Is there a specific reason you decided to get your eyes checked? _____

_____

☐ Yes	☐ No	Are you pregnant?
☐ Yes	☐ No	Do you have any allergies or hay fever? List any drug allergies: _____
☐ Yes	☐ No	Are you troubled with frequent headaches?
☐ Yes	☐ No	Are you diabetic?
☐ Yes	☐ No	Do you ever see double?
☐ Yes	☐ No	Have you or anyone in you family ever had a cataract?
☐ Yes	☐ No	Have you or anyone in your family ever had glaucoma?
☐ Yes	☐ No	Is there any blindness (one or both eyes) in your family?
☐ Yes	☐ No	Have you ever had a pair of glasses you couldn't wear?
☐ Yes	☐ No	Are you more sensitive to light than most people?
☐ Yes	☐ No	Do you have a particular difficulty in driving at night?
☐ Yes	☐ No	Are you a smoker?

Some activities have specific visual needs (e.g. sewing) or have specific visual risks (e.g. racquetball, welding). Please list any of your activities which might apply. **If under 18, list all sports teams.** _____

_____

Do you work on a computer (How many hours per day)? _____

PERSON RESPONSIBLE FOR THIS ACCOUNT _____

Address if different from patient's _____

Home Phone _____ Business Phone _____

INSURANCE (IF IT COVERS VISION CARE) _____ Primary Insured's Date of Birth _____

OVER *(Please See Reverse Side For Additional Information And Signature.)*

MEDICAL RELEASE

Patient's or authorized person's signature. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

Signed Date

Insured's or authorized person's signature. I authorize payment of medical benefits to the undersigned physician or supplier for services.

Signed Date

Please Note: We do not accept assignment on insurance claims. Financial responsibility begins at the time services are rendered. We will submit all VSP, Eyemed and UHC claims. For all other types of insurance, we will issue a "Superbill" for you to attach to your insurance form and submit.

During your examination:

1. Do not worry about making a mistake or giving a wrong answer.
2. Do not worry about your answers contradicting one another.
3. Do not hesitate to tell the doctor if you are unable to answer his questions.