

PATIENT INFORMATION

Social Security # _____-_____-_____	Last Name	First Name	Middle	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate ____/____/____	Age
Home Address	City	State	Zip	Best Phone # ()	<input type="checkbox"/> Mobile <input type="checkbox"/> Home	
Employer & Occupation:	How did you hear about us?			2nd Phone # ()	<input type="checkbox"/> Work <input type="checkbox"/> Cell	
I acknowledge the receipt of the HIPAA Privacy Notice: (signature)				OK to text? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Vision Plan Name:	Member Id:	Insured's Name	DOB	Social Security	Relationship	
Medical Plan Name:	Member Id:	Email:				

We will file an insurance claim for any plans under which we are providers for. If you have a question about which plans we are providers for, please ask our receptionist, and we will gladly assist. Payment is expected at time of treatment.

Patient History

1 Do you have? (please check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> eyestrain | <input type="checkbox"/> itchy eyes | <input type="checkbox"/> double vision |
| <input type="checkbox"/> dry eyes | <input type="checkbox"/> flashes of light | <input type="checkbox"/> blurred vision with or without glasses/contacts |
| <input type="checkbox"/> floaters | | <input type="checkbox"/> severe or frequent headaches |
| <input type="checkbox"/> frequent neck and shoulder pain | | |

2 Who is your primary physician: _____ Date of last physical: _____

3 Age of current glasses: _____ Date of last eye exam: _____

4 Have your eyes ever been dilated before? Yes No

5 Do you or any blood relatives (siblings, parents, grandparents, children) have? (please check all that apply)

	Self	Blood Relative		Self	Blood Relative
retinal/macular dis.	<input type="checkbox"/>	<input type="checkbox"/>	high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
cataracts	<input type="checkbox"/>	<input type="checkbox"/>	thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	asthma	<input type="checkbox"/>	<input type="checkbox"/>
diabetes	<input type="checkbox"/>	<input type="checkbox"/>	lung disease	<input type="checkbox"/>	<input type="checkbox"/>
high cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	heart disease	<input type="checkbox"/>	<input type="checkbox"/>

6 Are you pregnant? (if applicable) No Yes

7 Are you being treated for any medical conditions? No Yes

8 Circle one; if you smoke / drink / recreational drugs ? (if yes, how often?) _____

9 Are you taking any medications? No Yes

if yes, please list: _____

10 Are you allergic to any medications? No Yes

if yes, please list: _____

11 Do you have or have ever had any eye disease, injury, or surgery? No Yes

if yes, please list: _____

Patient Verification

The patient history that I have provided is true and complete to the best of my knowledge.	Signature (if under 18 years of age, parent signature is required)	Date:
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