

PATIENT INFORMATION

TODAY'S DATE _____

LAST NAME _____ FIRST _____ MI _____ BIRTHDATE _____

ADDRESS _____ HOME PHONE _____

CITY _____ STATE _____ ZIPCODE _____ WORK PHONE _____

OCCUPATION _____ EMPLOYER _____ CELL PHONE _____

SOCIAL SECURITY # ____/____/____ MEDI-CAL# _____ MEDI-CARE # ____/____/____/____

EMAIL _____ REFERRED BY _____

PATIENT MEDICAL HISTORY

Your primary care physician _____ Address _____

Primary reason for today's exam _____

Age of present glasses/contacts _____ Date of last Exam _____ From Dr. _____

Have your eyes ever been dilated before Yes No If, yes when? _____

Please list current medications you are taking _____

Are you allergic to any medications? Yes No If yes, list/type of reaction _____Do you ever see double? Yes No If yes, when? _____Do you ever have unusually frequent or severe headaches? Yes No Do you wear contacts? Yes NoAre you unusually sensitive to bright light? Yes No Do you sleep in your contacts? _____Do you have trouble with night vision? Yes No Solutions used for storage? _____Do you work with a computer? Yes No How often do you change lenses? _____Do you use cigarettes/tobacco? Yes No _____ Hours per dayAlcohol? Yes NoOther Substances? Yes No

What sports or hobbies do you enjoy? _____

Have you ever been treated for the following?

Eye Injury Yes NoEye Surgery Yes NoRetinal Detachment Yes NoRetinal Degeneration Yes NoGlaucoma Yes NoMigraine Headaches Yes NoDiabetes Yes NoTuberculosis Yes NoKidney Disease Yes NoHigh Blood Pressure Yes NoRecent Fever Yes NoSkin Problems Yes NoAllergic/Immunologic Yes NoHeart or Circulatory Disease Yes NoHeart Attack Yes NoLung Problems or Pneumonia Yes NoThyroid Problems Yes NoHIV / AIDS Yes NoLiver Disease or Hepatitis Yes NoBlood or Bleeding Problems Yes NoCancer Yes NoArthritis Yes NoEpilepsy or Seizures Yes NoRecent Weight Loss/Gain Yes NoEar/Nose/Throat Yes NoPsychiatric Yes No

Do any blood relatives have the following?

Diabetes Yes NoHigh Blood Pressure Yes NoThyroid Problems Yes NoMelanoma Yes NoGlaucoma Yes NoRetinal Detachment Yes NoRetinal Degeneration Yes NoCataracts Yes No

If yes, Who? _____

If yes, Who? _____

If yes, Who? _____

If yes, Who? _____

If yes, Who? _____

If yes, Who? _____

If yes, Who? _____

If yes, Who? _____

OVER

The following questions pertain to children 18 years or younger

PRENATAL HISTORY:

- Normal
- Other: _____

BIRTH HISTORY:

- Normal
- Other: _____

INFANT HISTORY:

- Normal
- Other _____

SCHOOL PERFORMANCE:

- Excellent
- Good
- Needs Improvement: _____

Payment is due when services are rendered.

Method of payment Cash Check Credit Card

Vision Insurance Carrier _____ ID # _____ Group _____

Health Insurance Carrier _____ ID # _____ Group _____

Primary Insured Name _____ Birthdate _____ SS# _____

Thank you for the opportunity to serve you.

Signature on File

1. I authorize use of this form on all my insurance submissions.
2. I authorize release of information to all my insurance carriers.
3. I understand that I am responsible for my bill.
4. I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers.
5. I authorize payment directly to my doctor.
6. I authorize release of information to opticians/optical suppliers whom I have asked to fill optical prescriptions.
7. I authorize release of information to health care providers for referral purposes, if needed.
8. I permit a copy of this authorization to be used in place of the original.

Name _____ Policy # _____
Please Print

Signature _____ Date _____