Dr. Bonnie Cameron
15260 Highway 105 west
Suite 127
Montgomery, Texas 77356
936-448-1200

Patients Name: _____SS#_____/____/_____Patients D.O.B ____/____/____

If Child, **Parent's Name**: _____ D.O.B _____/_____/_____

Address: _____ City:_____ State :_____Zip:_____

Cell Phone: _____ Home Phone: _____ Email: _____

Please Present Insurance Card at the Time of Service

Insurance Users **Primary's Name:** _____ D.O.B _____/_____/_____ SS# _____/____/_____
Vision Insurance Name: _____ Medical Insurance Name: _____
Medical: ID# _____ Vision: ID # _____

Do you have a chief Vision complaint today? Please Explain:

_____

_____

How long has it been since your last Eye exam?_____

Patient's Eye History: **Please Check The Following Conditions That Apply**

I Currently Use: Glasses ___ Contacts ___ Both ___ **Would you Like?** Glasses___ Contacts ___ Lasik ___ Ortho-K ___
I have Blurred Distance Vision _____ Watery Eyes _____ Dry Eyes _____ Eye Injury ____ Itchy/Burning Eyes _____
Blurred Near Vision ___ I see Floaters or Flashes ____ Eye Strain ____ Lazy Eye ____ Eye Surgery ____ Vision Loss ____
Color Blindness ___ Night blindness ___ Blurry Vision after reading for a long time ___
Glaucoma ____ Cataracts ____ Retina Disorders ____ Other _____

Patient's Medical History:

Diabetes ____ High Blood Pressure ___ High Cholesterol ___ Thyroid ___ Heart Disease ____ Arthritis ____ Cancer ____
Asthma ___ Hepatitis ___ Muscle Aches/Pains ___ Neurological Issues ____ Infectious Disease _____ Headaches _____
Genitourinary Issues _____ Currently Pregnant _____ Other:_____

Patient's Social History:

Computer/Phone/Tablet use? ____ How many hours a day? ____ Do you wear computer glasses? _____
Outdoor activities? ____ What Type? _____ Do wear prescription sunglasses? Yes ____ No ___
Tobacco Product use? ____ How much Daily? ____ How Long? _____ Drink Alcohol? ____ Frequency? _____

Family Health History?

Diabetes ____ High Blood Pressure ____ High Cholesterol ____ Thyroid ____ Heart Disease ____ Arthritis ____
Cancer ____ Cataracts ____ Glaucoma ___ Blindness ____ Macular Degeneration ____ Other _____

Please Present a List/ or List All Medications You Take Including Over the Counter Medications:

_____

_____

_____

Any Allergies to Medications? _____

Please Review your information and Sign below indicating information is Accurate to your Knowledge
HIPPA PRIVACY – I acknowledge that I have been presented a copy of the Notice of Privacy Policy

X _____ **Date:** _____
Signature of Patient or Legal Representative

Disclaimer: Patients own frames are welcome with the acknowledgement that If damaged we will be unable to replace your frames while inserting newly fabricated lenses. Those that would like to place an eye wear order with half down will need to pay the balance in 30-45 days or products will be sent back and deposits lost. Due to the complex nature of prescription eyewear and professional services No Refunds.