NAME: _____

IF CHILD, PARENT'S NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CELL: _____ HOME PHONE: _____

EMAIL: _____

PATIENT'S DATE OF BIRTH _____ VISION/HEALTH PLAN _____

INSURANCE USERS: PRIMARY'S NAME : _____ DATE OF BIRTH _____

ID # (THIS MAY BE THE SS#) _____ EMPLOYER: _____

PLEASE PRESENT INSURANCE CARD AT TIME OF SERVICE.

PLEASE CHECK THE FOLLOWING CONDITIONS THAT APPLY.

PATIENT'S EYE HISTORY: DATE OF LAST EXAM: _____

I CURRENTLY USE: GLASSES_____CONTACTS_____BOTH_____

BLURRED DISTANCE VISION_____ WATERY EYES_____DRY EYES_____EYE INJURY _____

BLURRED NEAR VISION_____ITCHY/BURN_____FLASHES/FLOATERS _____

EYE STRAIN_____LAZY EYE_____EYE SURGERY_____GLAUCOMA_____CATARACT _____

LOSS OF VISION_____RETINAL DISORDERS_____OTHER _____

PATIENT'S MEDICAL HISTORY:

DIABETES_____HIGH BLOOD PRESSURE_____HIGH CHOLESTEROL_____THRYOID _____

HEART DISEASE_____ARTHRITIS_____CANCER_____ASTHMA_____HEPATITIS _____

MUSCLE ACHES/PAINS_____NEUROLOGICAL ISSUES_____INFECTIOUS DISEASE _____

HEADACHES_____GENITO/URINARY ISSUES_____CURRENTLY PREGNANT _____

OTHER: _____

PATIENT'S SOCIAL HISTORY:

COMPUTEI/PHONE/TABLET USE?_____ HOW MANY HOURS A DAY?_____

OUTDOOR ACTIVITIES?_____WHAT TYPE _____

TOBACO PRODUCT USE?_____HOW MUCH DAILY?_____HOW LONG? _____

DRINK ALCOHOL?_____FREQUENCY? _____

FAMILY HEALTH HISTORY?

DIABETES_____HIGH BLOOD PRESSURE_____HIGH CHOLESTEROL_____THRYOID _____

HEART DISEASE_____ARTHRITIS_____CANCER_____CATARACTS_____GLAUCOMA _____

BLINDNESS_____MACULAR DEGENERATION_____OTHER _____

PLEASE LIST ALL MEDICATIONS YOU TAKE INCLUDING OVER THE COUNTER MEDICATIONS:

_____

_____

_____

ANY ALLERGIES TO MEDICATIONS? _____

PLEASE REVIEW YOUR INFORMATION AND SIGN BELOW INDICATING INFORMATION IS ACURATE TO YOUR KNOWLEDGE

HIPPA PRIVACY- I ACKNOWLEDGE THAT I HAVE BEEN PRSENTED A COPY OF THE NOTICE OF PRIVACY POLICY

X _____ DATE: _____

SIGNATURE OF PATIENT OR PATIENT'S LEGAL REPRESENTITIVE

OFFICE USE ONLY

PLAN_____AUTHORIZATION_____COPAY_____

PROCEEDURE:

$