PATIENT INFORMATION

GENERAL INFORMATION

First Name: M.I.: Last Name: Preferred (*nickname*):

Date of Birth: Male / Female Patient Social Security Number:

Street Address: City: State: Zip:

Phone (*cell*): Phone (*home*): Emergency Contact:

Email: Preferred Contact Method: *cell phone* | *email* | *text*

Patient: *employed* | *retired* | *student* Marital Status of Patient: *married* | *single* | *divorced* | *widowed*

Name of Employer/School: Occupation:

Caucasian | *Hispanic* | *African American* | *Asian*

How Were You Referred to Our Office?:

PRIMARY CARE PHYSICIAN

Name: Phone Number:

RESPONSIBLE BILLING PARTY

Name of Responsible Billing Party of Account: Relationship to Patient:

Street Address: City: State: Zip:

Phone Number: E-Mail:

RESPONSIBLE BILLING PARTY

I understand, that _____ ***am responsible for any balances not covered***
(Printed Name of Responsible)
by insurance/copays & agree to pay copays at the time of service. I agree to pay balances not covered by insurance upon receipt of statement.

_____

Signature of Responsible Date

VISION INSURANCE

VSP | EyeMed | Superior | Other

PRIMARY MEDICAL INSURANCE INFORMATION

Primary Medical Insurance: Primary Member Name:

Primary Medical Member D.O.B: Primary Medical Member SSN:

Group/Policy #: ID #:

Current Medications (*Prescriptions, Over-the-Counter & Dosage*):

Allergies *(Including Drug)*:

Are you pregnant or nursing?	*Yes* | *No*	**Do you (have you) use tobacco?**	*Yes* | *No*	**Quit Year:**
Do you drink alcohol?	*Yes* | *No* | *Socially*	**Do you use illegal drugs?**	*Yes* | *No*	

Height: **Weight:**

EYE HISTORY

Are you currently experiencing (or experienced) any of the following? *Circle all that apply*	
Burning | Itching | Redness	*Yes* | *No*
Dryness	*Yes* | *No*
Discharge	*Yes* | *No*
Excessive Tearing | Watering	*Yes* | *No*
Eye Pain | Soreness	*Yes* | *No*
Floaters | Spots	*Yes* | *No*
Halos	*Yes* | *No*
Headaches	*Yes* | *No*
Light Flashes	*Yes* | *No*
Light Sensitivity	*Yes* | *No*

Have you or a family member been treated any of the following? *Circle all that apply.*	
Cataracts	*Self* | *Family*
Crossed Eye	*Self* | *Family*
Eye Surgery	*Self* | *Family*
Eye Turn	*Self* | *Family*
Glaucoma	*Self* | *Family*
LASIK or RK	*Self* | *Family*
Macular Degenration	*Self* | *Family*
Retinal Detachment	*Self* | *Family*

Date of Last Eye Exam:

Date of Last Dilation:

MEDICAL HISTORY

Have you or a family member experienced (or been treated) for any of the following?*Circle all that apply.*

Allergies	*Self* | *Family*	Kidney Disease	*Self* | *Family*
Arthritis	*Self* | *Family*	Lupus	*Self* | *Family*
Asthma	*Self* | *Family*	Neurological Conditions	*Self* | *Family*
Blood | Lymph Disorder	*Self* | *Family*	Psychiatric Disorder	*Self* | *Family*
Cancer	*Self* | *Family*	Seizures	*Self* | *Family*
Diabetes	*Self* | *Family*	Sexually Transmitted Disease	*Self* | *Family*
Heart Disease	*Self* | *Family*	Stroke	*Self* | *Family*
High Blood Pressure	*Self* | *Family*	Thyroid Dysfunction	*Self* | *Family*
High Cholesterol	*Self* | *Family*		