

Personal Information

Mr. Mrs. Ms. Dr. Rev. _____ Gender M F Date _____
Street Address _____ City _____ State _____ Zip _____
Phone: Home _____ Work _____ Cell/Alt # _____ Date of Birth _____ Age _____
Social Security # _____ Occupation _____ Name of Parent/Spouse _____
Hobbies / Sports _____ Email Address _____

I have been provided with a copy of the HIPAA privacy policy to read. _____
Signature of Patient / Guardian _____ Date _____

Insurance Information (Major Medical) Financially responsible party: _____

Insurance Co _____ Member # _____ Group # _____
Primary Insured's Name _____ Insured's DOB _____ Insured's SS# _____
Address _____ Insured's Employer: _____

Insurance Information (Vision or Secondary)

Insurance Co _____ Member # _____ Group # _____
Primary Insured's Name _____ Insured's DOB _____ Insured's SS# _____
Address _____ Insured's Employer: _____

Medical and Ocular History

Do you wear Contact Lenses? Y N Brand? _____ Are you interested in contact lenses? Y N Do you wear glasses? Y N
When was your last eye exam? _____ Where was it? _____ Doctor? _____
Do you work at a computer terminal? Y N How many hours per day? _____ Are you interested in refractive surgery? Y N
Do you or any family member have a history of the following:

Eyes	NO		YES		Eyes Cont:	NO		YES	
	Self	Family	Self	Family		Self	Family	Self	Family
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning/Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic eye infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mucous discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crossed eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Red eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Retinal detachment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Tearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other				
Eye Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain/Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare/Light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

List any medications you are currently taking:

List your Past Ocular History and General Medical History (illness, surgery, injuries, treatments):

Comments on any Medical Condition:

Allergies Y N Explain: _____

Medical History Required by your Insurance Company

Musculoskeletal	NO		YES		Respiratory	NO		YES		Gastrointestinal	NO		YES		Have you ever been exposed to or infected with:	
	Self	Family	Self	Family		Self	Family	Self	Family		Self	Family				
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gonorrhea	Y	N
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	Y	N
Neurological					Hematologic/Lymphatic					Ears, Nose, Mouth, Throat				HIV	Y	N
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Syphilis	Y	N
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chlamydia	Y	N
Genitourinary					Swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry mouth/Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Kidneys	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular					Chronic ear infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergic/Immunologic						
Constitutional					Vascular disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine					Medicine Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Systemic Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

Comments on any Medical Condition:

Do you use tobacco products? Y N If yes, type, amount and how long? _____

Do you drink alcohol? Y N If yes, type, amount and how long? _____

Your insurance is meant to serve as a financial aid. We are happy to take assignment on your benefits. If you are not eligible for these benefits or are eligible for less than full coverage, **your signature indicates that you agree to be financially responsible for the balance not paid by your plan.** (Contact lens wearers- Rarely will insurance plans cover the entire exam, contact lenses, and professional fees for contact lens evaluations. Our office staff will make every effort to verify your benefits).

VERIFICATION OF BENEFITS IS NOT A GUARANTEE OF PAYMENT.

Signature: _____ Date: _____
Must be signed by Parent/Guardian if the patient is under 18 years of age.