If you come in with a medical condition, we may file with your major medical plan rather than your vision plan.

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:

	NO	YES Self	YES Family
Eyes			
Blindness	☐	☐	☐
Blurred vision	☐	☐	☐
Burning/Itching	☐	☐	☐
Cataracts	☐	☐	☐
Chronic eye infections	☐	☐	☐
Crossed eyes	☐	☐	☐
Double Vision	☐	☐	☐
Dry eyes	☐	☐	☐
Excessive Tearing	☐	☐	☐
Eye Allergies	☐	☐	☐
Eye Pain/Soreness	☐	☐	☐
Eye Surgery	☐	☐	☐
Flashes/Floaters	☐	☐	☐
Glare/Light sensitivity	☐	☐	☐

	NO	YES Self	YES Family
Eyes Cont:			
Glaucoma	☐	☐	☐
Halos	☐	☐	☐
Loss of vision	☐	☐	☐
Macular Degeneration	☐	☐	☐
Mucous discharge	☐	☐	☐
Red eyes	☐	☐	☐
Retinal detachment	☐	☐	☐
Retinal Problems	☐	☐	☐
Other			
Cancer	☐	☐	☐
Diabetes	☐	☐	☐
Headaches	☐	☐	☐
Heart Diseases	☐	☐	☐
High Blood Pressure	☐	☐	☐

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDING OTC)

ALLERGIES Y N Explain:

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

Comments on any Medical Condition:

Medical History Required by your Insurance Company

	NO	YES Self	YES Family
Musculoskeletal			
Arthritis	☐	☐	☐
Joint pain	☐	☐	☐
Neurological			
Seizures	☐	☐	☐
Other	☐	☐	☐
Genitourinary			
Kidneys	☐	☐	☐
Bladder	☐	☐	☐
Constitutional			
Fever	☐	☐	☐
Weight loss	☐	☐	☐
Weight gain	☐	☐	☐

	NO	YES Self	YES Family
Respiratory			
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Hematologic/Lymphatic			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
Swelling	☐	☐	☐
Cardiovascular			
Heart Problems	☐	☐	☐
Vascular disease	☐	☐	☐
Endocrine			
Thyroid problems	☐	☐	☐
Other glands	☐	☐	☐

	NO	YES Self	YES Family
Gastrointestinal			
Ulcers	☐	☐	☐
Other	☐	☐	☐
Ears, Nose, Mouth, Throat			
Sinus problems	☐	☐	☐
Chronic cough	☐	☐	☐
Dry mouth/Throat	☐	☐	☐
Chronic ear infections	☐	☐	☐
Allergic/Immunologic			
Hay Fever	☐	☐	☐
Medicine Allergies	☐	☐	☐
Systemic Allergies	☐	☐	☐
Psychiatric	☐	☐	☐

Have you ever been exposed to or infected with:

Gonorrhea	**Y**	**N**
Hepatitis	**Y**	**N**
HIV	**Y**	**N**
Syphilis	**Y**	**N**
Chlamydia	**Y**	**N**

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.