



# WELCOME

We are pleased to welcome you to our practice. Please print this form, fill it out completely and bring it to your scheduled appointment.

## PATIENT INFORMATION

Date \_\_\_\_\_

Patient Name \_\_\_\_\_

Last Name

First Name

M.I.

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Email \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birth date \_\_\_\_\_

Married  Widowed  Single

Separated  Divorced  Minor

Occupation \_\_\_\_\_

Patient Employer/School \_\_\_\_\_

Employer/School Address \_\_\_\_\_

Employer/School Phone (\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birth date \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

**Whom may we thank for referring you?**

\_\_\_\_\_

## INSURANCE

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birth date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to

\_\_\_\_\_  
Name of Insurance Company(ies)

Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. The consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

## PHONE NUMBERS

Home (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ Spouse's Work Phone (\_\_\_\_) \_\_\_\_\_

Best time and place to reach you \_\_\_\_\_

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

## EYE HEALTH HISTORY

Physician's Name \_\_\_\_\_

Date of last visit \_\_\_\_\_

Date of last eye exam \_\_\_\_\_

Name of Doctor \_\_\_\_\_

Do you wear glasses?  Yes  No

All the time  Occasionally

Reading  Driving  TV

Do you wear contacts?  Yes  No

Type \_\_\_\_\_ Hours/Day \_\_\_\_\_

Describe any problems you have with your contacts \_\_\_\_\_

**Please circle "Yes" or "No" to indicate if you have had any of the following"**

Bloodshot Eyes Yes / No Floaters/Spots Yes / No

Blurred Vision – Distance Yes / No Glaucoma Yes / No

Blurred Vision – Near Yes / No Headaches Yes / No

Burning Eyes Yes / No Itching Eyes Yes / No

Cataracts Yes / No Light Sensitive Yes / No

Color Vision, Poor Yes / No Loss of Vision Yes / No

Crossed Eyes Yes / No Migraine Headaches Yes / No

Discharge from Eyes Yes / No Night Vision – Poor Yes / No

Dizzy Spells Yes / No Red Eyes Yes / No

Double Vision Yes / No Seeing Halos Yes / No

Dry Eyes Yes / No Seeing Flashes Yes / No

Eye Infection Yes / No Temporary Loss of Vision Yes / No

Eye Injury Yes / No Twitching Eyelid Yes / No

Eye Strain Yes / No Vision Poor Yes / No

Fainting Spells, Blackouts Yes / No Watering Eyes Yes / No

## HEALTH HISTORY

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Please place a check mark to indicate if you have had any of the following. Also place a check mark to indicate if a blood relative has had any of the following problems.

	Yourself	Family Members		Yourself	Family Members
AIDS/HIV			Hepatitis (Type_____)		
Arthritis			High Blood Pressure		
Artificial Heart Valve			Kidney Disease		
Artificial Joints			Lazy Eye		
Asthma			Lupus		
Bleeding			Migraine Headaches		
Blindness			Pacemaker		
Cancer			Poor Color Vision		
Cataracts			Retinal Disease		
Chemical Dependency			Rheumatic Fever		
Diabetes			Shingles		
Drug Sensitivity			Skin Conditions		
Emphysema			Stroke		
Epilepsy			Thyroid Conditions		
Eye Surgery			Tuberculosis		
Glaucoma			Turned Eye		
Hay Fever			Are you pregnant? _____ Number of Children _____		
Heart Condition			Tobacco use _____ Alcohol use _____		

### MEDICATIONS

List any medications you are currently taking, including eye drops:

\_\_\_\_\_

\_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_

### ALLERGIES

List your allergies to medications or other substances:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## MEDICARE / MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits be made either to me or on my behalf to \_\_\_\_\_ for any services furnished to me by that provider.

Name of Doctor or Clinic

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

\_\_\_\_\_  
Signature of Beneficiary, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of Beneficiary, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to Beneficiary