PATIENT INFORMATION

Social Security #	Last Name	First Name	Middle	Sex ☐ Male ☐ Female	Birthdate / /	Age
Home Address	City	State	Zip	Best Phone # ( ) ☐Mobile ☐Home		
Employer & Occupation:	How did you hear about us?			2nd Phone # ( ) ☐Work ☐Cell		
I acknowledge the receipt of the HIPAA Privacy Notice: (signature)				OK to text? ☐Yes ☐ No		
Vision Plan Name:	Member Id:	Insured's Name DOB Social Security		Relationship		
Medical Plan Name:	Member Id:	Email:				

We will file an insurance claim for any plans under which we are providers for. If you have a question about which plans we are providers for, please ask our receptionist, and we will gladly assist. Payment is expected at time of treatment.

Patient History

1 Do you have? (please check all that apply)

☐ eyestrain ☐ itchy eyes ☐ double vision
☐ dry eyes ☐ flashes of light ☐ blurred vision with or without glasses/contacts
☐ floaters ☐ severe or frequent headaches
☐ frequent neck and shoulder pain

2 Who is your primary physician:______________________ Date of last physical:______________

3 Age of current glasses:______________________ Date of last eye exam:______________

4 Have your eyes ever been dilated before? ☐ Yes ☐ No

5 Do you or any blood relatives (siblings, parents, grandparents, children) have? (please check all that apply)

	Self	Blood Relative		**Self**	Blood Relative
retinal/macular dis.	☐	☐	high blood pressure	☐	☐
cataracts	☐	☐	thyroid problems	☐	☐
glaucoma	☐	☐	asthma	☐	☐
diabetes	☐	☐	lung disease	☐	☐
high cholesterol	☐	☐	heart disease	☐	☐

6 Are you pregnant? (if applicable) ☐ No ☐ Yes

7 Are you being treated for any medical conditions? ☐ No ☐ Yes

8 Circle one; if you smoke / drink / recreational drugs ? (if yes, how often?)______________

9 Are you taking any medications? ☐ No ☐ Yes

if yes, please list:______________________

10 Are you allergic to any medications? ☐ No ☐ Yes

if yes, please list:______________________

11 Do you have or have ever had any eye disease, injury, or surgery? ☐ No ☐ Yes

if yes, please list:______________________

Patient Verification

The patient history that I have provided is true and complete to the best of my knowledge.	Signature (if under 18 years of age, parent signature is required)	Date: