

Welcome to . Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

Mr. Miss Mrs. Ms. Male Female

 First Name MI Last Name Preferred Name

 Street Address City State Zip

 Social Security Number Date of Birth Home Phone - Include Area Code Day Phone

 Email Address Guardian Person Responsible for Account

 Cell Phone May we text this number? Yes No

 Emergency Contact Emergency Phone

PRIMARY INSURANCE INFORMATION

 Name and Address of Primary Insurance Company City State Zip

M F _____
 Insured's First Name MI Insured's Last Name

 Insured's Identification Number Group Number Insured's Date of Birth

Patient Relationship to Insured **Patient Status**

Self Spouse Child Other Single Married Other

Full Time Student Part Time Student Employed

SECONDARY INSURANCE INFORMATION

 Name and Address of Secondary Insurance Company City State Zip

M F _____
 Insured's First Name MI Insured's Last Name

 Insured's Identification Number Group Number Insured's Date of Birth

Patient Relationship to Insured

Self Spouse Child Other

Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to . I understand that will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

 Signature

 Date

Name _____

PATIENT HISTORY AND INFORMATION

Race

<input type="checkbox"/> American Indian Or Alaska Native	<input type="checkbox"/> Native Hawaiian Or Other Pacific Islander	Other Race _____
<input type="checkbox"/> Asian	<input type="checkbox"/> White	
<input type="checkbox"/> Black Or African American	<input type="checkbox"/> Declined To Specify	
<input type="checkbox"/> Hispanic Or Latino		

Ethnicity

Hispanic Or Latino Not Hispanic Or Latino Declined To

Preferred Language

English Chinese Dutch; Flemish French German Hindi

PRIMARY CARE PHYSICIAN

Primary Care Physician and Clinic Name _____

Address of Primary Care Physician City State Zip Phone

REFERRING PHYSICIAN

Referring Physician and Clinic Name _____

Address of Referring Physician City State Zip Phone

HEALTH HISTORY

What is the main reason for today's exam ? _____ When was your last exam ? _____

When was your last health exam ? _____

Past Eye Illnesses/Injury _____

Past Eye Surgeries: _____

Current Medications: _____

Current Eye Drops: _____

Medication Allergies: _____

EYE HISTORY

Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Dryness	<input type="radio"/> Yes <input type="radio"/> No	Strabismus (Crossed Eyes)	<input type="radio"/> Yes <input type="radio"/> No
Cataract	<input type="radio"/> Yes <input type="radio"/> No	Excess Tearing/Watering	<input type="radio"/> Yes <input type="radio"/> No	Blurred Vision Distance	<input type="radio"/> Yes <input type="radio"/> No
Macular Degeneration	<input type="radio"/> Yes <input type="radio"/> No	Eye Pain or Soreness	<input type="radio"/> Yes <input type="radio"/> No	Blurred Vision Near	<input type="radio"/> Yes <input type="radio"/> No
Retinal Detachment	<input type="radio"/> Yes <input type="radio"/> No	Foreign Body Sensation	<input type="radio"/> Yes <input type="radio"/> No	Distorted Vision (halos)	<input type="radio"/> Yes <input type="radio"/> No
Color Blindness	<input type="radio"/> Yes <input type="radio"/> No	Infection of Eye or Lid	<input type="radio"/> Yes <input type="radio"/> No	Double Vision	<input type="radio"/> Yes <input type="radio"/> No
Headaches	<input type="radio"/> Yes <input type="radio"/> No	Itching	<input type="radio"/> Yes <input type="radio"/> No	Floaters or Spots	<input type="radio"/> Yes <input type="radio"/> No
Glare/Light Sensitivity	<input type="radio"/> Yes <input type="radio"/> No	Mucous Discharge	<input type="radio"/> Yes <input type="radio"/> No	Fluctuating Vision	<input type="radio"/> Yes <input type="radio"/> No
Tired Eyes	<input type="radio"/> Yes <input type="radio"/> No	Drooping Eyelid	<input type="radio"/> Yes <input type="radio"/> No	Loss of Vision	<input type="radio"/> Yes <input type="radio"/> No
Amblyopia (Lazy Eye)	<input type="radio"/> Yes <input type="radio"/> No	Redness	<input type="radio"/> Yes <input type="radio"/> No	Loss of Side Vision	<input type="radio"/> Yes <input type="radio"/> No
Burning	<input type="radio"/> Yes <input type="radio"/> No	Sandy or Gritty Feeling	<input type="radio"/> Yes <input type="radio"/> No		