LET'S GET ACQUAINTED!!

Mrs., Miss, Ms.
Dr., Mr. _____ Date:_____

Address: _____ City:_____ State:_____ Zip:_____

Home/Cell Phone #:_____ Work #:_____

Birth date:_____ Age:_____ Soc. Sec. #:_____

Parents/Guardian: _____ Spouse:_____

E-Mail:_____ Employer:_____

How were you referred to us?

_____

_____

Insurance Liability Statement

It is your responsibility to know your insurance company policy, your benefits and your current eligibility for coverage at the time services are rendered by this office. It is also your responsibility to inform this office if you have changed insurance companies or benefit plans which would affect your current eligibility for coverage. If, for any reason, you are not eligible for insurance coverage at time of your visit to our office, you will be held responsible for any and all services rendered.

I UNDERSTAND THAT IF I AM NOT ELIGIBLE FOR INSURANCE SERVICE COVERAGE, OR FAIL TO INFORM THIS PROVIDER WITH CURRENT INSURANCE STATEMENT OF BENEFITS, I WILL BE HELD FINANCIALLY RESPONSIBLE FOR ANY AND ALL SERVICES RENDERED.

PATIENTS NAME:_____
PATIENTS/GUARDIANS SIGNATURE:_____
INSURANCE PROVIDER:_____MEMBER NAME&ID#_____

PERSONAL AND FAMILY HEALTH HISTORY

PLEASE CIRCLE YES OR NO

CONDITION	SELF	FAMILY	CONDITION	SELF	FAMILY
ALLERGIES	Y / N	Y / N	CATARACTS	Y / N	Y/ N
DIABETES	Y / N	Y / N	GLAUCOMA	Y / N	Y / N
HIGH BLOOD PRESSURE	Y / N	Y / N	MACULAR DEGENERATION	Y / N	Y / N
MS	Y / N	Y / N	STRABISMUS (LAZY EYE)	Y / N	Y / N
HEPATITIS	Y / N	Y / N	DRY EYES	Y / N	Y / N
DO YOU SMOKE	Y / N	Y / N	FLASHES/FLOATERS	Y / N	

OTHER OCULAR
HEALTH ISSUES: _____

HAVE YOU HAD ANY SURGERY ON YOUR EYES (LASIK, CATARACT, RETINAL): Y / N

WHAT KIND:_____

WHEN:_____ WHAT DOCTOR:_____

OVER→

2ND SIDE

DO YOU CURRENTLY WEAR EYEGLASSES? YES NO FULL TIME PART TIME

HAVE YOU EVER WORN CONTACT LENSES? YES NO FULL TIME PART TIME

DO YOU CURRENTLY WEAR CONTACT LENSES? YES NO FULL TIME PART TIME

ARE YOU INTERESTED IN WEARING CONTACTS? YES NO FULL TIME PART TIME

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY?

HOW MUCH TIME DO YOU CURRENTLY SPEND ON A COMPUTER? _____ HRS/DAY

TABLET _____ HRS/DAY

PHONE _____ HRS/DAY

DO YOU USE COMPUTER GLASSES? Y / N

ARE YOU INVOLVED IN ANY OCCUPATION, SPORT OR VOCATION WHICH MAY PLACE YOU AT RISK OF EYE INJURY FROM PROJECTILES, CHEMICALS OR CAUSTIC FUMES? PLEASE LIST...

DO YOU WEAR SAFETY GLASSES AT WORK? Y / N

ARE YOU TAKING ANY MEDICATIONS? Y / N PLEASE LIST...

ARE YOU ALLERGIC TO ANY MEDICATIONS? Y / N PLEASE LIST...

LADIES, ARE YOU PREGNANT OR NURSING? Y / N

*PATIENTS NAME:*_____

*PATIENTS SIGNATURE:*_____ *DATE:*_____