



PATIENT'S NAME _____ MALE FEMALE
First Middle Initial Last

ADDRESS _____
Street City State Zip Code

DATE OF BIRTH ____/____/____ MARITAL STATUS: SINGLE MARRIED DIVORCED/OTHER

OCCUPATION _____ EMPLOYER _____

DAY PHONE _____ SOCIAL SECURITY NO. _____

HOW WOULD YOU LIKE US TO SEND YOU REMINDERS ABOUT PICKUPS AND/OR FUTURE APPOINTMENTS?
BY: PHONE MAIL TEXT EMAIL _____

RESPONSIBLE PARTY FOR PAYMENT _____ RELATIONSHIP TO PATIENT _____

MEDICAL INSURANCE _____ VISION PLAN _____

SECONDARY INSURANCE _____ POLICY HOLDER _____ DOB ____/____/____

REFERRED BY: DR: _____ FAMILY/ FRIEND _____ OTHER _____

GENERAL MEDICAL CONDITIONS - CURRENT OR PAST

VISION / EYE CONDITIONS

	SELF	FAMILY		SELF	FAMILY
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	GI / Digestive	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Urinary / Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	STDs / Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>
Physiological	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pres.	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>

- Cataracts
- Macular Degeneration
- Glaucoma
- Headaches
- Diabetic Retinopathy
- Dry Eye
- Infection / Inflammation
- Flashes / Floaters
- Iritis / Uveitis / Eye Pain
- Retina Defects / Degen.
- Eye Injury _____
- Eye Surgery _____

DESCRIBE: _____

CURRENT MEDICATIONS: _____

ALL DRUG ALLERGIES: _____

SOCIAL HISTORY:

Are you: Pregnant Y N Nursing Y N Do you use: Alcohol Y N Tobacco Y N

DO YOU CURRENTLY WEAR CONTACTS Y N ARE YOU INTERESTED IN CONTACT LENSES? Y N

PLEASE READ: I understand that I am responsible for my bill regardless of insurance. I authorize the release of this information to all my insurance carriers, and for the doctor to act as my agent in helping me obtain payment from my insurance carriers. I authorize payment directly to my doctor, and permit a copy of this authorization to be used in place of the original. I understand that I am responsible for any co-payments, deductibles and noncovered services.

Signature (Patient or Guardian)

Date

I have received the **NOTICE OF PRIVACY PRACTICES** and have been provided an opportunity to review it.

Signature (Patient or Guardian)

Name of Authorized Persons