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