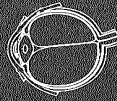


WELCOME



We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you.

PATIENT INFORMATION

INSURANCE

Date _____

Patient _____

Parent or Guardian (if under age 18) _____

Address _____

City _____ State _____ Zip _____

Sex: M F Age- _____ Birthdate _____

Single Married Widowed Separated Divorced

Home Phone: _____

Work Phone: _____ Exl. _____

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation- _____

Spouse's Employer _____

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co.- _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

Relationship _____ Date _____

EYE HEALTH HISTORY

Name of doctor _____

Date of last visit _____

Date of last eye exam _____

Do you wear glasses? Yes No

All the time Occasionally

Reading Driving TV

Do you wear contacts? Yes No

Type Hours/Day

Interested in wearing contacts today? Yes No

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 or Spots	Yes	No
Blurred Vision-Distance	Yes	No	Glaucoma	Yes	No
Blurred Vision-Near	Yes	No	Headaches	Yes	No
Burning	Yes	No	Itching Eyes	Yes	No
Eyes	Yes	No	Light Sensitive	Yes	No
Cataracts	Yes	No	Loss of Vision	Yes	No
Color Vision, Poor	Yes	No	Migraine Headaches	Yes	No
Crossed	Yes	No	Night Vision, Poor	Yes	No
Eyes Discharge from	Yes	No	Red Eyes	Yes	No
Eyes	Yes	No	Seeing Halos	Yes	No
Dizzy Spells	Yes	No	Seeing Flashes	Yes	No
Double Vision	Yes	No	Temporary	Yes	No
Dry Eyes	Yes	No	Loss of Vision	Yes	No
Eye Infection	Yes	No	Twitching	Yes	No
Eye Injury	Yes	No	Eyelid	Yes	No
Eye Strain	Yes	No	Vision Poor	Yes	No
Fainting Spells, Blackouts	Yes	No	Watering Eyes	Yes	No
	Yes	No		Yes	No

HEALTH HISTORY

Physician's Name _____

Date of last visit _____

Please circle "Yes" or "No" to indicate if you have had any of the following. Also circle to indicate if a blood relative has had any of the following problems.

	Yourself		Family Members			Yourself		Family Members	
	Yes	No	Yes	No		Yes	No	Yes	No
AIDS/HIV	Yes	No	Yes	No	Hepatitis (Type	Yes	No	Yes	No
Arthritis	Yes	No	Yes	No	High Blood Pressure	Yes	No	Yes	No
Artificial Heart Valve	Yes	No	Yes	No	Kidney Disease	Yes	No	Yes	No
Artificial Joints	Yes	No	Yes	No	Lazy Eye	Yes	No	Yes	No
Asthma	Yes	No	Yes	No	Lupus	Yes	No	Yes	No
Bleeding	Yes	No	Yes	No	Migraine Headaches	Yes	No	Yes	No
Blindness	Yes	No	Yes	No	Pacemaker	Yes	No	Yes	No
Cancer	Yes	No	Yes	No	Poor Color Vision	Yes	No	Yes	No
Cataracts	Yes	No	Yes	No	Retinal Disease	Yes	No	Yes	No
Chemical Dependency	Yes	No	Yes	No	Rheumatic Fever	Yes	No	Yes	No
Diabetes	Yes	No	Yes	No	Shingles	Yes	No	Yes	No
Drug Sensitivity	Yes	No	Yes	No	Skin Conditions	Yes	No	Yes	No
Emphysema	Yes	No	Yes	No	Stroke	Yes	No	Yes	No
Epilepsy	Yes	No	Yes	No	Thyroid Conditions	Yes	No	Yes	No
Eye Surgery	Yes	No	Yes	No	Tuberculosis	Yes	No	Yes	No
Glaucoma	Yes	No	Yes	No	Turned Eye	Yes	No	Yes	No
Hay Fever	Yes	No	Yes	No	Are you pregnant?	Number of children _____			
Heart Condition	Yes	No	Yes	No	Tobacco use	Alcohol use _____			

MEDICATIONS

List medications you are currently taking, including eye drops: _____

Pharmacy Name _____

Phone _____

ALLERGIES

List your allergies to medications or other substances: _____

EMERGENCY CONTACT

In case of emergency, contact (Specify someone who does not live in your household.)

Name _____

Relationship _____

Home Phone _____

Work Phone _____