

Account No. _____

New or Updated

PATIENT INFORMATION

Thank you for choosing our practice for your eyecare needs.

Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.
(PLEASE PRINT)

Date _____ Name _____
(Mr., Mrs., Ms., Dr.) First MI Last Nickname

Address _____ Apt. No. _____
City _____

State _____ Zip _____ Home Phone No. _____ Work Phone No. _____ Ext. _____

Date of Birth _____ Age _____ Sex _____ Occupation _____
(MM/DD/YYYY) (M/F)

Employer/School _____ Hobbies _____

Referred by (Circle one please) : Family Friend Doctor Yellow Pages Newspaper Coupon Walk-In Radio TV Recall Letter
Other _____

RESPONSIBLE PARTY

Name of person responsible for this account _____ Relationship to Patient _____
Contact Phone No _____ Address _____ Apt. No. _____
City _____ State _____ Zip _____ Employer _____
Work Phone No _____ Ext _____ Drivers License No. _____ / _____
Method of payment : Cash _____ Check _____ AMEX _____ Visa _____ MasterCard _____ Discover _____
(State)

VISION INSURANCE INFORMATION

Name of Vision Plan _____ Group Number _____
Name of Insured _____ Relationship to Patient _____
Date of Birth of insured _____ Insured social Security Number or Member ID Number _____

IMPORTANT HEALTH HISTORY

Reason for today's exam _____ Date of last exam _____ Name of last eye doctor _____
Please list all surgeries : _____
Please list all drug allergies : _____
Please list all medications you are currently taking : _____

Please **CHECK** any of the following that apply to you or (N) for none:

____ Frequent Headaches ____ Allergies ____ Pregnant ____ Sinus Trouble ____ Drug Allergies ____ Given birth in the last 6 months
Continue on the next pg. -->

Do you have a history of the following?

___ Cataracts ___ Turned or Lazy Eye ___ Arthritis
___ Arthritis
___ Blindness ___ High Blood Pressure ___ Thyroid
___ Thyroid
___ Glaucoma ___ Heart Condition ___ Diabetes
___ Diabetes

Does anyone in your family have a history of the following?

___ Cataracts ___ Turned or Lazy Eye
___ Blindness ___ High Blood Pressure
___ Glaucoma ___ Heart Condition

Have you ever had any of the following conditions involving your eyes? If yes please explain:

___ Eye Surgery ___ Eye infection or disease ___ Sensitivity to light ___ Eye injury ___ Floater or spots ___ Eyes burn/itch/water
___ Double Vision ___ Medical Treatment ___ Poor Distance Vision ___ Eye strain ___ Severe pain ___ Poor near vision

Explain: _____

Do you currently wear glasses? ___ Y ___ N Do you work at a computer or video display terminal? ___ Y ___ N If yes, how many hours? _____

When do you wear your Glasses?

___ All the time ___ Reading/Near work ___ Work safety ___ Distance task only ___ Computer work
___ Other (please explain) _____

Have you ever worn contacts? ___ Y ___ N Are you interested in wearing contact lenses? ___ Y ___ N

If so, what brand? _____ or ___ Unsure

If so what style? (Check all that apply) ___ Soft ___ Gas Permeable (RGP) ___ Bifocal ___ Progressive ___ Disposable ___ Toric
___ Conventional ___ Extended Wear ___ Clear ___ Color ___ Unsure

PUPIL DILATION

Dilation of the pupil is now considered standard procedure in comprehensive eye examinations. Dilating drops enlarge the size of the pupil (the center black spot of the eye) and allow the doctor a more thorough examination of the retina (back of the eye). Dilation assists in detection of glaucoma, cataracts, diabetic and hypertensive retinal changes, retinal holes, tears, and detachment as well as some types of tumors. The side effects are light sensitivity (4 to 6 hours) and trouble focusing up close (2 to 3 hours). The dilation is included in the exam fee. Even though the effect lasts about 4 to 6 hours, you should be able to drive home.

I want dilation: ___ Yes ___ No ___ Only if necessary

Signature or responsible party: _____

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such eyecare to third party payers and/or health practitioners. *I authorize and request my insurance company to pay directly to the eye doctor or ophthalmic group insurance benefits otherwise payable to me. I understand that my eyecare insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services and materials rendered on my behalf or my dependents.*

Signature of patient (Parent if patient is a minor)

Date