PATIENT HISTORY

Today's Date: _____

Patient Last Name: _____ First Name: _____ MI: ___ Sex: M___F___

Responsible Party Name (If different than Patient): _____

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

Mailing Address if different than above: _____

Patient's Date of Birth: _____ Patient/Guar SS#: _____

Email Address: _____ Hobbies: _____

Home Phone#: _____ Cell Ph#: _____ Work Ph#: _____

Employer: _____ Occupation: _____

Primary Ins: _____ Subscriber Name: _____ Sub ID: _____

Secondary Ins: _____ Subscriber Name: _____ Sub ID: _____

Date of Last Eye Exam: _____ Dilated: Y/N

Notification choice: ___ Text ___ Email ___ Phone call

MEDICAL HISTORY

What is your general health? _____

Do you have problems with any of the following:

Gastrointestinal:	Y/N	Ears/Nose/Throat:	Y/N	Skin:	Y/N	Endocrine (glands):	Y/N
Cardiovascular:	Y/N	Musculoskeletal:	Y/N	Respiratory:	Y/N	Allergic/immunologic:	Y/N
Headaches:	Y/N	Genitourinary:	Y/N	Mental:	Y/N	Eyes:	Y/N
High Blood Pressure:	Y/N	Nervous:	Y/N	Blood/Lymph:	Y/N		

Please answer all that apply:

Diabetes: Y/N Type: _____ Date of diagnosis: _____

Allergies: Y/N To what: _____ Symptoms: _____ Medications: _____

Tobacco Use: Y/N Alcohol Use: Y/N Others substances: Y/NCurrent Medications:

_____

Surgeries: Y/N Kind? _____

Name of Family Physician: _____ Date of last visit: _____

FAMILY HISTORY

High blood pressure: Y/N Relation: _____, Macular degeneration: Y/N..Relation _____

Diabetes: Y/N..Relation _____, Retinal detachment Y/N..Relation _____ ____

Glaucoma: Y/N..Relation_____, Cataracts: Y/N..Relation_____

Other Eye Conditions: Y/N... Relation _____What kinds_____

Personal Eye Information

Have you had any eye operations? Y/N..Type: _____ Date: _____

Have you had an eye injury? Y/N..Kind: _____ Date: _____

Do you have glaucoma? Y/N Cataracts? Y/N Dry Eyes? Y/N Blurred Vision? Y/N

Do you wear glasses? Y/N Do you wear contacts? Y/N Type: _____

Do you have any other eye problems? Y/N..What kind: _____

Whom may we thank for referring you? _____

Assignment and Release: I hereby authorize the physician to release any information required to process this claim. I also authorize my insurance benefits be paid directly to the physician and I understand I am financially responsible for all non-covered services.

Signature: _____ Date: _____