WELCOME TO OUR OFFICE!

(Please print and complete all entries)

Date ______________________

Patient (Last-First-Middle) ____Date of Birth _________________ Age______________
Address ____ City/St ____________________________ Zip____________________
Home Phone ________________________________ Cell Phone _____________________ e-mail _______________________________________
May we contact you by e-mail: [ ] Yes [ ] No
Hobbies _________________________________ Marital Status ___________________________________
Employer__________________________________ Occupation _______________________________________Work Phone _________________
Drivers License No.__________________________ Social Security No. ___________________________ Marital Status ___________________
Nearest relative not living with you ____ Relationship _____________ Phone ( ) ______________
Please list other family members and ages ____
Whom may we thank for referring you to our office? ____ Phone ____________________________
What are your main concerns about this visit?

Would you like to discuss the latest LASER surgery that reduces the need for glasses or contacts? Yes No

Legally responsible person (if patient a minor) ____ Home phone _______________________
Address ____ City/St ___________________________ Zip ____________________
Employer ___________________________________ Occupation ________________________________ Work Phone ______________________
Drivers License No.____________________________ Social Security No. ___________________________ Marital Status ___________________

Spouse: [ ] of patient [ ] of Legally responsible person ____ Home phone _____________________
Address ____ City/St ________________________________ Zip _________________
Employer ________________________________ Occupation ____ Work Phone _________________
Drivers License No. _________________________ Social Security No. ___________________________

METHOD OF PAYMENT TODAY WILL BE: [ ] Cash [ ] Check [ ] VISA/Mastercard/Discover

Vision Insurance ________________________ Group No. and Membership No. ________________________ Name of Insured _________________
Major Medical Insurance Co. ____________________________ Group No./Membership No. _________________________

Medical History Questionnaire

Patient Eye History: (Please check all that apply) When was your last eye exam ? _______________________

_____ Blurred distance vision _____ Headaches _____ Eye infections _____ Loss of vision
_____ Blurred near vision _____ Hay fever or allergies _____ Styes _____ Light flashes or floaters
_____ Poor night vision _____ Dryness _____ Cataracts _____ Eye pain or soreness
_____ Tired eyes _____ Redness _____ Glaucoma _____ Distorted vision or Halos
_____ Use a computer _____ Sandy/ Gritty feeling _____ Retinal Disease _____ Double vision
_____ Glare or light sensitivity _____ Watery or Itchy eyes _____ Eye injury or surgery _____ Lazy eye/ crossed eyes
_____ Other: ____

Patient Medical History:

_____ Headaches _____ High Blood Pressure _____ Arthritis
_____ Allergies _____ Heart problems _____ Thyroid Disorders
_____ Sinus trouble _____ Diabetes _____ Fainting/ dizziness
_____ other:____
Primary Physician____________________________ Phone____________________________ Last Medical Exam ___________________
List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies) and give purpose:

Please list any medications you are allergic to: ____
____
List all major injuries, surgeries and/or hospitalizations you have had: ____
____Ar
e you pregnant and/or nursing? [ ] no [ ] yes

Social History

Do you drive? [ ] yes [ ] no If yes, do you have visual difficulty when driving? [ ] yes [ ] no If yes, please describe: ___________________________
____
_____ Smoke or use tobacco _____ Drink Alcohol _____Illegal Drugs
_____ Exposed to excess sunlight _____ Sexually transmitted diseases

Please turn this form over and complete side two

Family History
Please note any family history (parents, grandparents, siblings and or children, living or deceased) for the following medical conditions:

		RELATIONSHIP TO PATIENT			
Blindness	_____	____________________	Diabetes	_____	____________________
Cataract	_____	____________________	Heart Disease	_____	____________________
Crossed Eyes	_____	____________________	High Blood Pressure	_____	____________________
Glaucoma	_____	____________________	Kidney Disease	_____	____________________
Macular degeneration	_____	____________________	Lupus	_____	____________________
Retinal Detachment/ Disease	_____	____________________	Thyroid Disease	_____	____________________
Arthritis	_____	____________________	Other: ____		
Cancer	_____	____________________	____		

Review of Systems
Do you currently, have any problems in the following areas: (If YES, please explain and list medications)

SYSTEM		EXPLAIN AND LIST MEDICATIONS
INTEGUMENTARY (Skin)	_____	____
NEUROLOGIC	_____	____
Headaches	_____	____
Migraines	_____	____
Seizures	_____	____
EARS, NOSE, MOUTH, THROAT		
Allergies	_____	____
Hay Fever	_____	____
Sinus Congestion	_____	____
Runny Nose	_____	____
Post-Nasal Drip	_____	____
Chronic Cough	_____	____
Dry Throat/ Mouth	_____	____
RESPIRATORY		
Asthma	_____	____
Chronic Bronchitis	_____	____
Emphysema	_____	____
VASCULAR		
Diabetes	_____	____
Heart Pain/ Problems	_____	____
High Blood Pressure	_____	____
Vascular Disease	_____	____
GASTROINTESTINAL		
Diarrhea	_____	____
Constipation	_____	____
GENITOURINARY	_____	____
(genitals/ kidney/ bladder)		
BONES/ JOINTS/ MUSCLES		
Rheumatoid Arthritis	_____	____
Muscle Pain	_____	____
Joint Pain	_____	____
LYMPHATIC/ HEMATOLOGIC		
Anemia	_____	____
Bleeding Problems	_____	____
ENDOCRINE	_____	____
(Thyroid / other glands)		
PSYCHIATRIC	_____	____

Most insurances do not cover services rendered at 100%. The patient is responsible at the time of service for any necessary co-payments and overages not expected to be paid by your insurance unless other arrangements are made in advance with the receptionist. Your insurance company will be billed by our office for their portion, and may take up to 45 days to pay. We can not guarantee that your insurance will pay for the services rendered. Any unpaid balances will be billed to you after your insurance payment is received.

The patient is responsible for any balance not paid or covered by the insurance. Any accounts with balances over thirty days will be charged interest at 1 1/2% per month (18% per annum) on the unpaid balance with a minimum charge of $1.50 per month. I understand I am ultimately responsible for payment regardless of insurance coverage. I agree to pay court costs and reasonable attorney's fees if a delinquent balance is placed with a collection agency or attorney for collection or suit. I certify the above information is true and correct to the best of my knowledge.

Signature____ Date______________________________
If not patient, relationship to patient ____