# 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'll be glad to help you. We look forward to meeting your eye care needs with professional vision care.*

## A PATIENT INFO

Date ______________________

SS/HIC/Patient ID # ______________________

Patient Name ______________________
Last Name

______________________
First Name Middle Initial

Address ______________________

City ______________________

State ______________ Zip ______________

E-mail ______________________

Sex ☐ M ☐ F Age ________ Birthdate ______________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ______ years

Occupation ______________________

Patient Employer/School ______________________

Employer/School Address ______________________

______________________

Employer/School Phone (_____) ______________________

Spouse's Name ______________________

Birthdate ______________ SS# ______________

Spouse's Employer ______________________

Whom may we thank for referring you? ______________________

## B INSURANCE

Who is responsible for this account? ______________________

Relationship to Patient ______________________

Insurance Co. ______________________

Group # ______________________

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ______________________

Birthdate ______________ SS# ______________

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. This 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

______________________
Please print name of Patient, Parent, Guardian or Personal Representative

______________ ______________
Date Relationship to Patient

## C PHONE NUMBERS

Home (______) ______________ Cell (______) ______________ Spouse's Work Phone (______) ______________ Ext ______

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 (______) ______________ Ext ______

## D 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 ______________________

______________________

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

| Condition | Yes | No | Condition | Yes | No |
|---|---|---|---|---|---|
| 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 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 |


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## E HEALTH HISTORY

Physician's Name ______________________ Date of last visit ______________

Place a mark on "Yes" or "No" to indicate if you have had any of the following. Also place a mark to indicate if a blood relative has had any of the following problems.

| | Yourself | | Family Members | | | Yourself | | Family Members | |
|---|---|---|---|---|---|---|---|---|---|
| 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 any medications you are currently taking, including eye drops:

______________________________

______________________________

Pharmacy Name______________________

Phone (______)______________________

## ALLERGIES

List your allergies to medications or other substances:

______________________________

______________________________

______________________________

______________________________

## F 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