

Name _____ SS# _____ Today's Date _____

Birth Date _____ Age _____ Gender _____ E-mail address _____

Preferred Phone # _____ Home/Work/Cell Alternate Phone # _____ Home/Work/Cell

Address _____ City _____ State _____ Zip _____

Are you currently: employed full time/part-time student full time/part-time retired Date of Last Eye Examination _____

Present Occupation (or grade in school): _____ Employer (or school attending) _____

Marital Status : single / married / other Hours per day on the computer? _____ How did you hear about us? _____

Do you smoke? none minimal moderate heavy Do you drink alcohol? none minimal moderate heavy

List any medications or vitamins you currently take (Rx and over-the-counter) _____

Do you have any allergies to medications? YES NO If YES, list the medications _____

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) _____

List any surgeries you have had (cataract, appendectomy) _____

YOUR MEDICAL HISTORY applicable.	Circle any problems you currently have.				Mark NONE if	Other	No ne
General Health:	Fever	Weight loss	Weight gain	Weakness	Tiredness		
Eyes:	<u>Eye Injuries/Surgeries:</u> <input type="checkbox"/> Blurred vision <input type="checkbox"/> Double vision <input type="checkbox"/> Light Sensitivity <input type="checkbox"/> Headaches	(eye & date) <input type="checkbox"/> Itching <input type="checkbox"/> Burning <input type="checkbox"/> Redness <input type="checkbox"/> Tired Eyes	<input type="checkbox"/> Dryness <input type="checkbox"/> Tearing / Watery eyes <input type="checkbox"/> Discharge	<input type="checkbox"/> Foreign body sensation <input type="checkbox"/> Eye pain <input type="checkbox"/> Styes			
Ears, Nose, Throat:	Hearing Loss	Ear ache	Sore throat	Stuffy nose	Dry mouth		
Heart/Circulation:	<i>High blood pressure</i>	Racing pulse	Slow pulse	Light headed	Chest pain		
Lungs/Breathing:	Shortness of breath	Cough	Congestion				
Stomach/Intestines:	Upset stomach	Pain	Constipation	Ulcers	Hernia		
Kidney/Bladder:	Pain on urination	Frequency	Blood in urine	Back pain			
Muscle/Bone/Joint:	Arthritis	Swelling	Tenderness	Cramps	Stiffness		
Skin:	Rashes	Warts	Growths				
Neurological:	Migraines	Numbness	Seizures	Paralysis	Dizzy		
Psychiatric:	Anxiety	Depression	Insomnia				
Endocrine:	Diabetes: # of years	<i>Last Blood Sugar / HA1C:</i>		Thyroid			
Blood/Lymph:	High cholesterol	Anemia	Leukemia	Lymphoma			
Allergy/Immunology:	Sneezing	Hay fever	Hives	Lupus			
Females Only	Are you pregnant?	Nursing?					

Family History: List family members (Mother, Father, Grandparent, Sibling) who have or have had any of the following

Blindness	Lazy Eye / Eye Turn	Cancer
Cataracts	High blood pressure	Arthritis
Glaucoma	Heart Disease	Diabetes
Macular Degeneration	Thyroid Disease	<i>Other inherited disease</i>

Since your insurance coverage is likely to change each year, please take a few moments to update our records regarding your insurance coverage. It is imperative that you provide us with accurate and current information. It is necessary that the requested information be filled out completely to file your claim. Missing or incorrect information may result in a denial of the claim. As a courtesy, we will gladly file claims with your insurance company. We will do our best to determine your benefits prior to your visit; however, this is not a guarantee of benefits. You are responsible for any amounts that your insurance does not cover. Thank you for your cooperation.

-----**Vision Insurance**-----

To be billed if exam is strictly routine

(Please Circle)

Davis / Eyemed / Spectera / Superior / VSP Policy Holder's full(legal) name: _____

Policy Holder's date of birth _____ Policy Holder's SS# _____

Patient's Relationship to Policy Holder: (please circle) Self/Spouse/Child/Other Policy Holder's Employer _____

-----**Medical Insurance**-----

To be billed if there is a medical reason for the office visit

(Please Circle)

BCBS / Coventry / Humana / Freedom Network / Medicare / TriCare / United Healthcare / Other: _____

If different Policy Holder from Vision Insurance: Policy Holder's full(legal) name: _____

Policy Holder's date of birth _____ Policy Holder's SS# _____

Patient's Relationship to Policy Holder: (please circle) Self/Spouse/Child/Other Policy Holder's Employer _____

*I authorize the release of any medical or other information necessary to process this claim. I agree to pay any non-covered charges and co-pays as instructed by my insurance company. I also request payment of benefits either to myself or to the party who accepts assignment.

*I acknowledge that I have been offered or received a copy of the privacy practices of this office.

(Patient or Guardian Signature)

(Date Signed)