WELCOME!

We strive to provide the highest level of professional eye care in a friendly and caring environment and to maximize our patients' quality of life; utilize the most advanced technology and professional skills; and inspire confidence through patient education.

Today's Date_____ Date of Birth _____ Age _____

☐Mr. ☐Mrs. ☐Ms. ☐Dr._____

First Middle Last

_____

Street Address City State Zip

Primary Contact Number_____ ☐HOME ☐CELL ☐WORK

Secondary Contact Number_____ ☐HOME ☐CELL ☐WORK

Tertiary Contact Number _____ ☐HOME ☐CELL ☐WORK

Email Address_____

Spouse or Parent Name_____

School/Employer_____ Grade/Occupation_____

How will you settle your account today?

____Cash ____Check ____Credit Credit

How did you hear of our office?

Referral (Name)_____

Other_____

I consent to the use and disclosure of my health information for the purposes of treatment, payment, and health care operations. In addition, I give my permission for your office to leave telephone messages confirming appointments and any other related office matters.

Patient or Authorized Signature _____

Date _____

If you are signing as a personal representative of the patient, describe your relationship to the patient.

Relationship to Patient_____ Print Name_____

Professional fees are due when services are rendered unless prior arrangements are made. A deposit of 50% is required toward the total cost of glasses before an order can be placed. The remaining balance is due at the time of dispensing. When eyeglasses are purchased through insurance, the balance is due in full when the order is placed. When ordering contact lenses, total payment is due before the order can be placed, unless otherwise specified. Thank you for your cooperation.

Primary Medical Insurance
Policy Holder's Social Security Number _____

☐**Medicare** ☐**MVP** ☐**BlueCrossBlueShield** ☐**Empire** ☐**Aetna**

☐**CDPHP** ☐**Other**_____

Secondary Medical Insurance (if applicable)

☐**Medicare** ☐**MVP** ☐**BlueCrossBlueShield** ☐**Empire** ☐**Aetna**

☐**CDPHP** ☐**Other**_____

Vision Insurance
Policy Holder's Social Security Number _____

☐**Davis Vision** ☐**VSP** ☐**EyeMed** ☐**NTA** ☐**Other** _____

Patient's relationship to insured ☐Self ☐Spouse ☐Child ☐Other

Patient's status ☐Single ☐Married ☐Other

☐Employed ☐Full-time Student ☐Part-time Student

When was your last eye exam? _____

Please list any current medications (RX or over-the-counter)

_____ _____

_____ _____

_____ _____

Any allergies to medications? ☐Yes ☐No

_____

Any other known allergies? ☐Yes ☐No

_____

Social History

Do you use tobacco products? ☐Yes ☐No

Do you have a dependency on any drug/alcohol substance(s)? ☐Yes ☐No

Do you have any habits that have special/specific vision demands? ☐Yes ☐No

Do you currently wear glasses? ☐Yes ☐No

If yes, do you have any problems with them? ☐Yes ☐No

Do you wear contact lenses? ☐Yes ☐No

If yes, do you have any problems with them? ☐Yes ☐No

Do You Experience...

Glare or Reflection	☐Yes ☐No	Soreness	☐Yes ☐No
Sensitivity to Light	☐Yes ☐No	Itchiness	☐Yes ☐No
Eye Strain	☐Yes ☐No	Redness	☐Yes ☐No
Headaches	☐Yes ☐No	Gritty Feeling in Eyes	☐Yes ☐No
Trouble Seeing at Night	☐Yes ☐No	Blurry Distance Vision	☐Yes ☐No
Burning	☐Yes ☐No	Blurry Near Vision	☐Yes ☐No
Dryness	☐Yes ☐No	Double Vision	☐Yes ☐No
Watery Eyes	☐Yes ☐No	Objects Floating In Vision	☐Yes ☐No

Sudden Loss of Vision ☐Yes ☐No	Other: _____
Fainting or Dizziness ☐Yes ☐No	_____
Flashes of Light ☐Yes ☐No	_____
Nausea ☐Yes ☐No	_____

Family Medical History

Blindness	☐Yes ☐No	Glaucoma	☐Yes ☐No
High Cholesterol	☐Yes ☐No	Eye Diseases	☐Yes ☐No
Diabetes	☐Yes ☐No	Other:	_____
Heart Disease	☐Yes ☐No		_____
High Blood Pressure	☐Yes ☐No		_____

Patient Medical History

Allergies	☐Yes ☐No	Heart Disease	☐Yes ☐No
Arthritis	☐Yes ☐No	High Blood Pressure	☐Yes ☐No
Asthma	☐Yes ☐No	Kidney Problems	
Cataracts	☐Yes ☐No	Nerves	☐Yes ☐No
Cancer	☐Yes ☐No	Skin Disorder	☐Yes ☐No
Diabetes	☐Yes ☐No	Nausea	☐Yes ☐No
Eye Injury	☐Yes ☐No	Fainting or Dizziness	☐Yes ☐No
Eye Surgery	☐Yes ☐No	Other:	_____
Glaucoma	☐Yes ☐No		_____
Heart Disease	☐Yes ☐No		_____