Patient Information Form

DEMOGRAPHIC INFORMATION

Last Name:		Gender: MALE / FEMALE
First Name:	M.I.:	Date of Birth: / /
Title:	Suffix:	Social Security Number:
Address 1:		Marital status:
Address 2:		Employment status:
City:		Employer:
State:	Zip Code:	Occupation:
Primary Phone: ( )		Preferred Language:
Daytime Phone: ( )		Race:
Cell Phone: ( )		Ethnicity:
Email:		Referral:
Last eye exam:		Communication Pref: MAIL EMAIL PHONE

INSURANCE INFORMATION

Insurance 1	*Insurance 2*
Insurance Name:	Insurance Name:
Insured ID:	Insured ID:
Policy Group:	Policy Group:
Relationship to insured: SELF / SPOUSE / DEPENDENT	Relationship to insured: SELF / SPOUSE / DEPENDENT

Insured Party Information		*Insured Party Information*	
Last Name:		Last Name:	
First Name:	M.I.:	First Name:	M.I.:
Title:	Suffix:	Title:	Suffix:
Date of Birth: / /		Date of Birth: / /	
Social Security Number:		Social Security Number:	
Address 1:		Address 1:	
Address 2:		Address 2:	
City:		City:	
State:	Zip Code:	State:	Zip Code:
Primary Phone: ( )		Primary Phone: ( )	
Daytime Phone: ( )		Daytime Phone: ( )	
Gender:		Gender:	
Employer:		Employer:	
Additional Info:		Additional Info:	

Most insurance policies pay only a portion of your total charges. If you have questions about your coverage, *please contact your representative.* We do not guarantee the accuracy of benefit information given to us by insurance companies. If verification for insurance coverage is not available upon visit, all professional fees will be charged at the time of service.

Please understand that financial responsibility for your account is yours, not your insurance company's.
Note to Medicare Patients: Medicare will not pay for refractive services or other services deemed not medically necessary.

REASON FOR VISIT AND PRIMARY CARE PHYSICIAN

Reason for Visit: ESTABLISHED PATIENT EXAM / NEW PATIENT EXAM / EMERGENCY / CONTACT FIT

Additional Information:____

Primary Care Physician:

Date of Last visit:

Are you currently under the care of a Physician? YES / NO

If yes, please list the reason:____

____

HISTORY OF PRESENT ILLNESS (HPI)

Are you currently experiencing any of the following?

[ ] Blurred Distance Vision
[ ] Blurred Near Vision
[ ] Burning Eyes
[ ] Double Vision
[ ] Dry Eyes
[ ] Eye Strain
[ ] Flashes of Light
[ ] Gritty Feeling Eyes
[ ] Headaches
[ ] Itchy Eyes
[ ] Loss of Vision
[ ] Night Vision Problems
[ ] Objects Floating in Vision
[ ] Pain in Eyes
[ ] Red Eyes
[ ] Sensitivity to Light
[ ] Watery Eyes

PATIENT HISTORY

Medical History

Are you currently experiencing or have you ever experienced any problems in the following areas?

[ ] AIDS/HIV
[ ] Allergy
[ ] Arthritis
[ ] Blood
[ ] Cancer
[ ] Cardiovascular
[ ] Constitutional
[ ] Diabetes
[ ] Ears, Nose, Throat, Mouth
[ ] Endocrine
[ ] Gastrointestinal
[ ] Genitourinary
[ ] Heart Disease
[ ] Hematologic/Lymphatic
[ ] High Blood Pressure
[ ] Immunologic
[ ] Integumentary (Skin)
[ ] Kidney Disease
[ ] Musculoskeletal
[ ] Neurological
[ ] Psychiatric
[ ] Respiratory
[ ] Thyroid Disease

Are you pregnant? YES / NO

Are you nursing? YES / NO

Ocular History

Indicate any history for the following conditions:

[ ] Blindness
[ ] Cataract
[ ] Glaucoma
[ ] Macular Degeneration
[ ] Retinal Detachment/Disease

How many hours per day do you use a computer?

Do you currently wear:	Contacts: YES / NO	Glasses: YES / NO
If no, are you interested in contacts? YES / NO		[ ] Always
If yes, what type of contact lenses?		[ ] Computer
[ ] Disposable soft		[ ] For Reading
[ ] Regular soft		[ ] Only while driving
[ ] Gas permeable		[ ] Sunglasses
[ ] Other:		

Are you interested in laser vision correction? YES / NO

Ocular Surgery

Eye Surgery: YES / NO

Date of Surgery: ______________________________

Type of Surgery: ______________________________

Medications and Allergies

List all current medications, including vitamins, supplements and birth control: ______________________________

____

____

____

Are you allergic to any medications: YES / NO

If yes, please list: ______________________________

Family Ocular History and Family Systemic History

Please indicate any family history for the following conditions:

	Mother	Father	Sister	Brother	Grandparent	Child
AIDS/HIV	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Arthritis	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Blindness	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Cancer	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Cataract	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Diabetes	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Glaucoma	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Heart Disease	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
High Blood Pressure	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Kidney Disease	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Macular Degeneration	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Retinal Detachment/Disease	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Thyroid Disease	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

Social History

Do you use tobacco products? YES / NO

Do you drink alcohol? YES / NO

Do you use other substances? YES / NO

Do you participate in sports? YES / NO

If yes, please list: ______________________________

Most insurance policies pay only a portion of your total charges. If you have questions about your coverage, *please contact your representative.* We do not guarantee the accuracy of benefit information given to us by insurance companies. If verification for insurance coverage is not available upon visit, all professional fees will be charged at the time of service.

Please understand that financial responsibility for your account is yours, not your insurance company's.
Note to Medicare Patients: Medicare will not pay for refractive services or other services deemed not medically necessary.

PRIVACY POLICY ACKNOWLEDGEMENT

Before we collect your information, we want to make sure that you are aware of our privacy policy. The policy explains why we collect your information and how it will be used. We have posted our policy in the office and have a copy available if you would like to take one and review it.

Please sign below to verify that we have informed you of our privacy policy and have made a copy available to you.

Patient Full Name____
(Please Print)

Responsible Party____________________ Relationship to Patient__________
(Please Print)

Signature________________________________ Date ______________

Witness__________________________