WELCOME TO OUR OFFICE

PATIENT INFORMATION (PLEASE PRINT) **CONFIDENTIAL**

NAME (Mr, Mrs, Ms, Minor): ______ DATE: ______

ADDRESS: ______ AGE: ______ BIRTH DATE: ______

CITY: ______ STATE: ______ ZIP: ______ HOME PHONE: ( ) ______

OCCUPATION: ______ WORK PHONE: ( ) ______

EMPLOYER/SCHOOL: ______ CELL PHONE: ( ) ______

HEALTH INSURANCE: ______ ID# ______

VISION INSURANCE: ______ SOCIAL SECURITY NUMBER: ______

PERSON TO CONTACT IN CASE OF EMERGENCY: ______ PHONE: ( ) ______

YOUR REASONS FOR VISITING OUR OFFICE TODAY (PLEASE CHECK ALL THAT APPLY)

___ **ROUTINE EYE EXAM**
(NO SPECIFIC PROBLEMS)
___ LOST OR BROKEN GLASSES
___ WANT NEW GLASSES
___ BLURRED DISTANCE VISION
___ BLURRED NEAR VISION
___ HEADACHES- HOW OFTEN? ______
___ **MEDICAL EVALUATION**

___ EYES WATER
___ EYES BURN
___ EYES ITCH
___ EYES FEEL DRY
___ RED EYES
___ GLARE
___ PAIN
___ SEE "SPOTS"
___ SEE FLASHING LIGHTS

___ **CONTACT LENS EXAM**
__SOFT __DISPOSABLE __COLOR
__RGP (RIGID GAS PERMEABLE)
__BIFOCAL CONTACT LENSES
___ PROBLEMS WITH CURRENT
___ CONTACT LENSES
___ OTHER ______

MEDICAL HISTORY

CHANGE IN HEALTH STATUS? Y / N IF YES, EXPLAIN: ______

ANY CHANGE/ADDITION TO CURRENT MEDICATION(S)? Y / N IF YES, LIST: ______

INSURANCE INFORMATION

NAME OF **VISION PLAN**: ______

NAME OF INSURED: ______ RELATIONSHIP TO PATIENT: ______

BIRTHDATE: ______ SOCIAL SECURITY NUMBER: ______

NAME OF EMPLOYER: ______ WORK PHONE: ( ) ______

ADDRESS OF EMPLOYER: ______ CITY: ______ STATE: ______ ZIP: ______

HEALTH INSURANCE COMPANY: ______ ID# ______

INS. CO. ADDRESS: ______ CITY: ______ STATE: ______ ZIP: ______

HOW MUCH IS YOUR DEDUCTIBLE? ______

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, LIST: ______

INSURANCE ASSIGNMENT AND RELEASE

I HEREBY AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION REQUIRED TO PROCESS THE CLAIM FOR THE PROFESSIONAL SERVICES AND DETERMINING INSURANCE BENEFITS PAYABLE FOR RELATED SERVICES. I ALSO AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO THE PHYSICIAN AND I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES.

______ SIGNATURE OF PATIENT, GUARDIAN OR PERSONAL REPRESENTATIVE ______ DATE

______ PLEASE PRINT NAME OF PATIENT, GUARDIAN OR PERSONAL REPRESENTATIVE ______ RELATIONSHIP TO PATIENT

THANK YOU FOR THE PRIVILEDGE OF ALLOWING US TO BE OF SERVICE TO YOU.