PATIENT INFORMATION

DATE: ____________________ PATIENT'S NAME: ____

DATE OF BIRTH: ___________________________________ MARITAL STATUS: __________________________

SOCIAL SECURITY #: ______________________________ EMAIL: ______________________________________

IF CHILD, PARENT'S NAME: ____

ADDRESS: ____

CITY: ____________________________________ STATE: ________________ ZIP: ____________________

HOME PHONE: _______________________________ BUSINESS PHONE: ____________________________

PATIENT'S OCCUPATION/SCHOOL: ____________________ EMPLOYER/GRADE: ______________________

FAMILY PHYSICIAN: ____ LAST CHECKUP: _________________

LAST EYE EXAM: __________________ DOCTOR: ____

TYPE OF MEDICAL INSURANCE: ______________________________ ID# ________________________________

TYPE OF VISION INSURANCE: ________________________________ ID# ________________________________

NAME OF INSURED: ___________________________________ INSURED'S DATE OF BIRTH: _______________

INSURED'S EMPLOYER: ____

RELATIONSHIP TO INSURED: SELF SPOUSE DEPENDENT CHILD

HOBBIES THAT REQUIRE SPECIAL VISUAL NEEDS: ____

____

CONTACT LENS WEARERS

TYPE OR BRAND OF CONTACT LENSES: ____

SOLUTIONS USED: ____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process claims. I also request payment of government benefits either to myself or to the party who accepts assignment.

Signature: ____ Date: ________________________

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to undersigned physician or supplier.

Signature: ____ Date: ________________________

REVIEWED: ____________________ DATE: _______________

PATIENT HISTORY FORM

PATIENT'S NAME: ______________________ TODAY'S DATE: ______________

FAMILY HISTORY				**RELATIONSHIP**			
DIABETES	NO	YES	?	P	GP	B/S	OTHER
HIGH BLOOD PRESSURE	NO	YES	?	P	GP	B/S	OTHER
BLINDNESS	NO	YES	?	P	GP	B/S	OTHER
GLAUCOMA	NO	YES	?	P	GP	B/S	OTHER
RETINA PROBLEMS	NO	YES	?	P	GP	B/S	OTHER

MEDICAL HISTORY	**CURRENT MEDICATIONS**		
ASTHMA	NO	YES	______
ARTHRITIS	NO	YES	______
CANCER	NO	YES	______
DIABETES	NO	YES	______
HEART DISEASE	NO	YES	______
HIGH BLOOD PRESSURE	NO	YES	______
KIDNEY PROBLEMS	NO	YES	______
HIGH CHOLESTEROL	NO	YES	______
MIGRAINE HEADACHES	NO	YES	______
NEUROLOGICAL DISORDERS	NO	YES	______
PSYCHOLOGICAL DISORDERS	NO	YES	______
ALLERGIES/SINUSITIS	NO	YES	______
THYROID	NO	YES	______

OTHER DISORDERS ______________________

MEDICATION ALLERGIES ______________________

EYE HISTORY			
CATARACTS	NO	YES	______
CROSSED OR LAZY EYE	NO	YES	______
GLAUCOMA	NO	YES	______
EYE INJURY	NO	YES	______
EYE SURGERY	NO	YES	______
EYE INFECTION	NO	YES	______
RETINOL PROBLEMS	NO	YES	______

SYMPTOMS			
EYE PAIN	NO	YES	______
DOUBLE VISION	NO	YES	______
FLASHES/FLOATERS	NO	YES	______
LOSS OF VISION	NO	YES	______
PERSISTENT HEADACHES	NO	YES	______

REVIEWED ______________ DATE ______________