PATIENT PROFILE DATE:

NAME	D.O.B.	AGE	GENDER
ADDRESS	CITY	STATE	ZIP
OCCUPATION	CELL-HOME PHONE	E-MAIL	
EMPLOYER NAME	VISION-MEDICAL INSURANCE : SUBSCRIBER NAME :	D.O.B. : SSN:	
IS THIS EXAM FOR ☐ SPECTACLE ☐ CONTACT LENSES ☐ OTHER:		PATIENT SSN - -	
DATE OF LAST EXAM	REASON FOR TODAY'S EXAM	LANGUAGE(S)	
DO YOU PRESENTLY WEAR EYE GLASSES? ☐ YES ☐ NO HOW OLD? ____	DO YOU PRESENTLY WEAR CONTACT LENSES? ☐ YES ☐ NO HOW OLD? _____		

	YES	NO
Are you a new patient	☐	☐
Do you take any medication? List:	☐	☐
Are you allergic to any medication-anesthetic? List:	☐	☐
Do you have frequent headaches? Describe:	☐	☐
Do you or any family members have Diabetes? Who? How long?	☐	☐
Do you or any family members have High Blood Pressure? Who? How Long?	☐	☐
Do you or any family members have Heart problems? Who? How Long?	☐	☐
Do you or any family members have any other medical problems? Describe	☐	☐
How often do you see your family physician for the above condition(s)?	☐	☐
Do you or any family members have Glaucoma? Who? How long?	☐	☐
Do you or any family members have any other disease? Describe	☐	☐
Do you or any family members have Cataract? Who? How long?	☐	☐
Do you have any anxiety or psychological conditions?	☐	☐
Are you currently smoking, taking any drugs, alcohol or other substances? Describe	☐	☐
Are you pregnant?	☐	☐
Have you ever had an eye injury?	☐	☐
Have you ever had an eye or eyelid surgery?	☐	☐
Do you have a lazy eye or crossed eyes? Describe	☐	☐
Do you work at a computer terminal? Hours per day?	☐	☐

I DO/DO NOT wish to have my eyes dilated today. I am aware of the benefits of this procedure in the early detection of any eye diseases, tumors and other related disorders. I am also aware of the duration of the blurred vision after the dilating drops are instilled and will use caution when leaving the doctor's office. I have received a copy of the Informed Consent for Dilation.

(Parent if Minor) Signature: _____ Date: _____

I authorize the release of medical records for claims processing.

Preferred method of payment:

Cash☐ Check☐ ☐DISC. MC VISA AMEX ☐ Insurance Billing Copay _____ Auth# _____

Trans # _____ Amount $: _____ Filed: _____