PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ M.I. ____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DATE OF BIRTH: _____

HOME PHONE: (____) _____ CELL PHONE: (____) _____

SS #: _____ MARITAL STATUS: _____ STUDENT: FT OR PT

E-MAIL ADDRESS: _____

PATIENT EMPLOYER: _____ OCCUPATION: _____

PRIMARY CARE PHYSICIAN: _____ PHONE #: _____

PHARMACY NAME: _____ PHONE #: _____

GUARANTOR INFORMATION

RELATIONSHIP OF PATIENT TO GUARANTOR: SELF ____ SPOUSE ____ PARENT ____ OTHER ____

LAST NAME: _____ FIRST NAME: _____ M.I. ____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (____) _____ CELL PHONE: (____) _____

SS#: _____ D.O.B: _____

PREFERRED LANGUAGE: _____

RACE: _____

ETHNICITY: _____

PREFERRED COMMUNICATION: MOBILE _____ HOME PHONE _____ MAIL _____

THERE WILL BE A $50.00 CHARGE FOR MISSED AND NO SHOW APPOINTMENTS, SO PLEASE CALL TO CANCEL.

INSURANCE

PRIMARY INSURANCE: _____

MEMBER ID: _____ GROUP #: _____

POLICY HOLDER: _____ SS#: _____ D.O.B: _____

SECONDARY INSURANCE: _____

MEMBER ID: _____ GROUP#: _____

POLICY HOLDER: _____ SS#: _____ D.O.B: _____

EMERGENCY CONTACT NAME: _____

PHONE #: (___) _____ RELATIONSHIP: _____

FINANCIAL RESPONSIBILITY AGREEMENT STATEMENT

I understand that I/We are responsible for all charges even those not paid by insurance.

Should the services of an outside agency be required for collection of the account, I/We agree to pay costs of collections including but not limited to collection agency fees of 35%, Attorney's fees, Interest, and court costs.

Signature: _____ Date: _____

PATIENT HEALTH HISTORY

Patient name: _____ DOB ___/___/___ Gender: Male Female

Primary Care Physician: _____ Do you currently wear Glasses ? **YES / NO**

Do you wear contacts? **YES / NO** Type: _____ Do you wear drug store readers? **YES / NO**

Please Indicate if any of the conditions apply to you or a family member (blood relatives only)

DISEASE/CONDITION FOR YOURSELF			DISEASE/CONDITION OF FAMILY MEMBER(S)		FAMILY MEMBER(S)
Eye Turn/Lazy Eye	YES	NO	Blindness	YES/NO	_____
Glaucoma	YES	NO	Eye Turn/Lazy Eye	YES/NO	_____
Macular Degeneration	YES	NO	Glaucoma	YES/NO	_____
Retinal Detachment	YES	NO	Macular Degeneration	YES/NO	_____
Dry Eyes	YES	NO	Retinal Detachment	YES/NO	_____
Cataract	YES	NO	Cataract	YES/NO	_____

Women: Are you pregnant? YES / NO

REVIEW OF SYSTEMS:

Auto Immune Disorder? Yes No _____

Cardiovascular Disorder? Yes No Hypertension, Heart Disease, Stroke, High Cholesterol_____

Blood Disorder? Yes No _____

Cancer? Yes No _____

Endocrine? Yes No Diabetes – Type 1 Type 2 Thyroid Hormone _____

Neurological Disorder? Yes No _____

Respiratory Disorder? Yes No Asthma COPD Emphysema _____

Psychiatric Disorder? Yes No Depression Bi-Polar Anxiety Schizophrenia_____

Genital/Urinary Disorder? Yes No HIV Positive Herpes Chlamydia _____

Current Smoker? Yes No **Previous Smoker?** Yes No **Never a Smoker** _____

Any major surgeries, Eye, Kidney, Brain, Thyroid, Lung etc... _____

_____

Medications: _____

_____

ALLERGIES: _____

Signature: _____ **Date:** _____