Name:______________________________ Date of Birth:___________________

Home Address:______________________________ City:________________ Zip Code:___________

Cell Phone #:____________________ 2nd Phone #:____________________ Last 4 of Social-Security:_______

Email Address:______________________________ Race:_____________ Ethnicity:______________

Emergency Contact Name:______________________ Phone #:____________________ Relation:__________

Ocular History: (Please ✓ any of the following that apply to you)

Last Eye Exam:________________ Eye Surgeries / Injuries:____

Macular Degeneration ☐ Glaucoma ☐ Blindness ☐ Retinal Detachment ☐ Eye Strain w/ Headaches ☐

Are you a contact lens user: Y or N If yes, what brand:________________ Are you interested in contact lens fitting: Y or N

Medical History: (Please ✓ any of the following that apply to you)

Medication: Are you taking any medications? No ☐ Yes ☐ (If yes, please list ALL):__________________________

____

Allergic/Immunologic: Environmental Allergy ☐ Rheumatoid-Arthritis ☐ Lupus ☐ Other(s):________________

Drug Allergies: No ☐ Yes ☐ (If yes, list ALL) ____

Tobacco Use: None ☐ Current Smoker ☐ Former Smoker ☐ ***Alcohol Use:*** None ☐ Socially ☐ Daily ☐

Primary Care Physician:________________________ Location:______________________________

Medical Diagnosis: Any medical diagnosis by a doctor? **No** ☐

Musculoskeletal: Fibromyalgia ☐ Ankylosing Spondylitis ☐ Osteoarthritis ☐ Other(s):__________________

Cardiovascular: Heart Disease ☐ Hypertension ☐ Stroke ☐ Vascular-Disease ☐ Other(s):________________

Neurological: Epilepsy ☐ Alzheimer ☐ Parkinson ☐ Other(s):____________________________________

Genitourinary: STD / Viral Herpetic / Chlamydia ☐ Other(s):____________________________________

Psychiatric: Depression ☐ Panic Disorder ☐ Schizophrenia ☐ Other(s):____________________________

Hematologic/Lymphatic: Anemia ☐ Leukemia ☐ Other(s):____

Respiratory: Asthma ☐ Bronchitis ☐ Emphysema ☐ Other(s):____________________________________

Endocrine: Insulin Dependent Diabetic ☐ Non-Insulin Dependent Diabetic ☐ Thyroid Dysfunction ☐

Hormonal Dysfunction ☐ Other(s): ____

Integumentary: Eczema ☐ Rosacea ☐ Psoriasis ☐ Other(s): ____________________________________

Family-History: Diabetes ☐ Hypertension ☐ Glaucoma ☐ Macular-Degeneration ☐ Color Blindness ☐

Blindness ☐ Heart Disease ☐ Cancer ☐ Other(s):____

Financial Responsibility Statement & HIPAA Practice Acknowledgement:

All payments are due at the time of service rendered. Your insurance is not a substitute for payment, as all benefits quoted are not a guarantee of payment. It is your responsibility to pay for any co-pays, deductibles, or any other balance not covered under your insurance. In signing this statement you agree to be financially responsible for all charges.

I authorize any holder of medical information about me, to release to the Health Care Financing administrative and its agents any information needed to determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. Photocopy of this assignment is considered to be as valid as the original.

Patient / Legal Guardian Signature:__________________________________ **Date:** ____________________