Patient Form

Title	First Name	Middle Name	Last Name

Gender ☐ Male ☐ Female

Street Address

Street Address Line 2

City	State	Postal/Zip Code	Country

SSN *(If Billing Insurance)*	Patient Birthdate	Home Phone
Cell Phone	Work Phone	Patient E-mail

Employer	Occupation

Account Responsibility (if different from patient)

Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner

Insurance-Vision

Insurance Company Name

Subscriber Name	Relationship to Patient	Subscriber DOB

Subscriber SSN/ID	Subscriber Employer

Insurance-Medical

Insurance Company Name

Subscriber Name	Relationship to Patient	Subscriber DOB

Subscriber SSN/ID	Subscriber Employer

Medical History *Select any of the following medical conditions that you currently have.*

☐ None	☐ Coronary Artery Disease	☐ Hypertension	☐ Prostate Cancer
☐ Anxiety	☐ COPD	☐ HIV/AIDS	☐ Radiation Treatment
☐ Arthritis	☐ Depression	☐ Hypercholesterolemia	☐ SeizuresStroke
☐ Atrial Fibrillation *(Irregular Heartbeat)*	☐ Diabetes	☐ Hyperthyroidism	☐ Other
☐ Bone Marrow Transplantation	☐ End Stage Renal Disease	☐ Hyporthyroidism	
☐ BPH	☐ GERD	☐ Leukemia	
☐ Breast Cancer	☐ Hearing Loss	☐ Lung Cancer	
☐ Colon Cancer	☐ Hepatitis	☐ Lymphoma	

Surgical History *Have you had any surgeries on the following organs?*

- ☐ None
- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast Biopsy R L
- ☐ Lumpectomy R L
- ☐ Mastectomy R L
- ☐ Colon Cancer Resection
- ☐ Colon: Diverticulitis
- ☐ Inflammatory Bowel Disease
- ☐ Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Biological Valve Replacement
- ☐ Coronary Artery Bypass Surgery
- ☐ Heart Transplant
- ☐ Mechanical Valve Replacement
- ☐ PTCA
- ☐ Joint Replacement Hip R L
- ☐ Joint Replacement Knee R L
- ☐ Kidney Biopsy
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Kidney: Nephrectomy
- ☐ Liver: Hepatectpmy
- ☐ Liver Transplant
- ☐ Liver: Shunt
- ☐ Ovaries: Endometriosis
- ☐ Ovarian Cancer
- ☐ Ovarian Cyst
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreatectomy
- ☐ Prostate Biopsy
- ☐ Prostate Cancer
- ☐ Prostate: TURP
- ☐ Rectum: APR
- ☐ Low Anterior Resection
- ☐ Basal Cell Carcinoma
- ☐ Melanoma
- ☐ Skin Biopsy
- ☐ Squamous Cell Carcinoma
- ☐ Spleen
- ☐ Testicles
- ☐ Uterus: Fibroids
- ☐ Uterus: Uterine Cancer
- ☐ Uterus: Cervical Cancer
- ☐ Other

Ocular History

- ☐ None
- ☐ Allergic Conjunctivitis
- ☐ Blepharitis
- ☐ Cataract R L
- ☐ Contact Lenses
- ☐ Corneal Dystrophy
- ☐ Diabetic Retinopathy, Background
- ☐ Diabetic Retinopathy, Proliferative
- ☐ Dry Eyes
- ☐ Glasses
- ☐ Glaucoma R L
- ☐ Macular Degeneration R L
- ☐ Macular ERM R L
- ☐ Narrow Angles
- ☐ Ocular Hypertension
- ☐ Ophthalmic Migraine
- ☐ PVD R L
- ☐ Pseudoexfoliation
- ☐ Strabismus
- ☐ Vitreous Floaters R L
- ☐ Other

Ocular Surgery

- ☐ None
- ☐ Blepharoplasty R L
- ☐ Cataract Surgery R L
- ☐ Corneal Transplant R L
- ☐ Eye Muscle Surgery R L
- ☐ Intravitreal Injections R L
- ☐ LASIK R L
- ☐ PRK R L
- ☐ Ptosis Repair R L
- ☐ Punctal Plugs R L
- ☐ Retinal Laser R L
- ☐ Trabeculectomy R L
- ☐ Yag Capsulotomy R L
- ☐ Other

Please list all medications or provide a list to the doctor

Please list all eye drops you are currently using

Please list any specific allergies

Do You Smoke ◯ Yes ◯ No	If Yes, How Long and How Many Packs a Day?
Are you... ☐ Pregnant ☐ Nursing ☐ Neither	

Review of Systems

- ☐ Heart Disease
- ☐ Heart Attack
- ☐ High Cholesterol
- ☐ Vascular Disease
- ☐ Rapid Heart Beat
- ☐ Artificial Heart Valve
- ☐ Blood Thinner
- ☐ Pacemaker
- ☐ Cough
- ☐ Wheezing
- ☐ Congestion
- ☐ Shortness Of Breath
- ☐ Pseudoexfoliation Syndrome
- ☐ Poor Vision
- ☐ Eye Pain
- ☐ Tearing
- ☐ Redness
- ☐ Jaw Pain
- ☐ Scalp Tenderness
- ☐ Amaurosis Fugax
- ☐ Loss Of Vision
- ☐ Fever
- ☐ Chills
- ☐ Weight Loss
- ☐ Stuffy Nose
- ☐ Ear Ache
- ☐ Dry Mouth
- ☐ Upset Stomach
- ☐ Diarrhea
- ☐ Constipation
- ☐ Flomax
- ☐ Incontinence
- ☐ Joint Pains
- ☐ Stiffness
- ☐ Artificial Joints Within Past 2 Years
- ☐ Arthritis
- ☐ Rash
- ☐ Rosacea
- ☐ Headache
- ☐ Stroke
- ☐ Paralysis
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Thyroid Abnormalities
- ☐ Bleeding
- ☐ Anemia
- ☐ Hay Fever
- ☐ Hives
- ☐ High Blood Pressure
- ☐ Steroid Responder
- ☐ Narrow Angles
- ☐ Pregnancy Or Planning A Pregnancy
- ☐ Seizure
- ☐ Diabetes
- ☐ Allergies
- ☐ Allergy To Adhesive
- ☐ Allergy To Lidocaine
- ☐ Mrsa

Family Ocular History

☐ Macular Degeneration ☐ Blindness ☐ Other:

☐ Glaucoma ☐ Cataracts ☐ ANSWER IS NO TO ALL

How Did You Hear About Our Office?

☐ Yellow Pages ☐ Family/Friend ☐ Website ☐ Google/Internet Search ☐ Insurance ☐ Other:

Payment Policies: A 50% downpayment is required for all eyewear purchases with the remaining balance due at time of the dispensing. Contact lenses must be paid for at the time of order due to the fact that they are a controlled prescription device. payment in full is expected for all professional fees at the time of service. If you have vision or health insurance, we will submit a claim to your insurance company for you. The balance on your account will remain your responsibility. We expect payment if full within 60 days regardless of insurance pending. Any account with a balance over 60 days, without attempt to make arrangements, will be sent to a collection agency. Authorization: I authorize and request that my insurance carrier may pay less than the total bill for services. I agree to be responsible for payment of all services/products rendered on my behalf or my dependents, regardless of insurance pending. I also understand that a monthly 1.5% financial charge (18% annually) may be added to any account balance over 60 days old or may be sent to a collection agency.

I accept the above terms and conditions concerning payment of my account. ◯ **Yes** ◯ **No** Signature Date

Acknowledgment of receipt of Notice of Privacy Practices: Our notice of Privacy Practices is available for your review on our website. Please take the time to review this document and if you have any questions, feel free to contact our office or ask us in person during your visit.

I acknowledge that I have reviewed the Notice of Privacy Practices ◯ **Yes** ◯ **No** Signature Date