PATIENT INFORMATION

Name_____ Birthdate _____ Gender ____ Date _____

Address, City, State, ZIP _____

Phone (H) _____(W) _____(C) _____

Social Security Number _____ Primary Care Physician _____

Married Single Divorced Spouse Deceased

Occupation _____ Employer _____

Emergency Contact _____ Phone _____

May we give medical information to this person? ____Preferred Pharmacy _____ Location _____

Email address _____ Preferred Method of Contact phone email text

Is it ok to leave a detailed message on: Home Phone Cell Phone Work Phone Email ?

May we collect medication information via our e-prescribing software? Y N

I authorize this office to discuss my treatment and/or financial information with the following person(s):

Name_____Relationship_____ Treatment Info Financial Info

Name_____Relationship_____ Treatment Info Financial Info

Spouse's Name _____ SS# _____

Spouse's Birthdate _____ Employer _____

Responsible Party (If different than patient) _____ Phone _____

Address, City, State, ZIP _____

Vision Insurance _____ Member # _____ Group # _____

Primary Medical Insurance _____Member # _____ Group # _____

Secondary Insurance _____ Member # _____ Group # _____

FINANCIAL RESPONSIBILITY

The undersigned accepts full responsibility for the services and materials provided by this office at the time of service. I hereby authorize the release of health care information related to treatment to these insurance companies for the purposes of evaluating claims and administering benefits. I acknowledge ultimate financial responsibility for balances not paid by my insurance companies. A deposit may be required before any materials are ordered. If parents are separated or divorced, the parent accompanying the child to the office is responsible for payment of any fees incurred. An administrative charge of 1.0% of the balance will be assessed monthly to balances greater than 60 days old. If any balance is not paid within 90 days, the undersigned agrees to pay reasonable fees incurred by this office while collecting the amount due (to include but be limited to: collection agency fees, court costs, and attorney fees).

_____ _____

Signature Date Relation to patient (if minor)

MEDICAL HISTORY

Do you or have you had any problems related to the following?

Stomach/Digestion	y/n	Muscles/Bones	y/n	Skin	y/n
Nervous System	y/n	Allergy/Immune System	y/n	Blood	y/n
Psychiatric Status	y/n	Genitourinary System	y/n	Lungs	y/n
Heart/Blood Pressure	y/n	Ear/Nose/Throat	y/n	Glands/Hormones	y/n

Estimated height _____ Estimated weight _____

Do you have diabetes? y/n If so, for how long? _____ Last glucose _____ HgA1c _____ reading?

List all medications that you take:

_____

_____

List all medications to which you are allergic and your reaction to them:

_____

Do you have headaches? If so, describe them _____

Please list any other health problems: _____

Do you use alcohol? y/n Other substances? y/n Smokeless tobacco? y/n

Smoking status: never a smoker former smoker some day smoker every day smoker

FAMILY HISTORY

High Blood Pressure y/n Relationship _____ Diabetes y/n Relationship _____

Macular Degeneration y/n Relationship _____ Glaucoma y/n Relationship _____

Cataracts y/n Relationship _____ Detached Retina y/n Relationship _____

Amblyopia y/n Relationship _____ Other _____

OCULAR HISTORY

Do you wear glasses? y/n

Do you wear contact lenses? y/n If so, what type/brand? _____

Have you had any eye injures or surgeries? y/n If so, explain _____

Do you experience any of the following with your eyes?

Blurred vision	y/n	Double vision	y/n
Dryness	y/n	Excess tearing	y/n
Sandy/gritty feeling	y/n	Itching	y/n
Redness	y/n	Discharge	y/n
Pain	y/n	Burning	y/n
Light sensitivity	y/n	Flashes/floaters	y/n