

Welcome to our office

Please print the following valuable information to help us serve you better.

Name _____ E-mail _____

Address _____

City / State / Zip _____

Phone # _____ Alternate # _____

Occupation _____ Employer _____

Age _____ Birth Date _____ Social Security # _____ Marital Status: S M D W

Primary Health Insurance Plan _____ Secondary _____

Vision Plan _____ Insured Name _____ Insured D.O.B. _____

GENERAL HEALTH			
	YES	NO	IN FAMILY
High Blood Pressure			
Diabetes			
Heart Disease			
Thyroid			
Headaches			
Arthritis			
Cancer			
Allergy / Sinus			
Other			

EYE HISTORY			
	YES	NO	IN FAMILY
Glaucoma			
Cataracts			
Lazy Eye			
Eye Surgery			
Eye Injuries			
Macular Degeneration			
Retinal Detachment			
Color Blindness			
Other			

CURRENT VISION PROBLEMS		
	YES	NO
Blur at Distance		
Blur at Near		
Double Vision		
Floaters		
Flashing Lights		
Eye Pain		
Eyes Itch or Burn		
Eyes Tear		
Other		

Do you smoke? Yes No Former Smoker? Yes No Year quit _____

Do you drink alcohol? Yes _____ / drinks per week Socially only No

Current medications: _____

Are you allergic to any medications? Yes No (specify) _____

Medical Doctor _____ Last Physical _____

Last Eye Exam (date) _____ Doctor's Name _____

Do you wear Glasses? Yes No Contact lenses? Yes No Type _____

Are you interested in Contact Lenses? Yes No Glasses? Yes No

How were you referred to us? _____

Dilation Procedures: Dilation includes use of topical medication to dilate the pupil to facilitate a complete view of the eye, to detect disease.

Advisement: Wear dark sunglasses after the procedure. Near vision will be blurred for approximately 2 hours. Eyes will be sensitive to light. Care should be taken when driving as some people experience blur at distance after dilation.

Assignment and Release: I hereby authorize the physician to release any information required to process this claim. I also authorize my insurance benefits to be paid directly to the physician and I understand that I am financially responsible for all non covered services.

Patient Signature: _____ Date: _____