

Name _____ Nickname _____	Cell phone _____
Address _____	Home phone _____
City _____ State _____ Zip _____	Work phone _____
DOB _____ Age _____ SS# _____	Occupation _____
	Referred by _____

Sex Male Female Marital Status Single Married Widowed Relationship to insured: Self Spouse Child

Person responsible for account _____ relationship _____
Date of Birth of person responsible for account _____
Primary Insurance _____ ID# _____ Group # _____
Secondary Insurance _____ ID# _____ Group # _____

Briefly explain the primary reason for your visit today: _____

MEDICAL, FAMILY & SOCIAL HISTORY: (Please indicate if you or any of your family members has had any of the following:

	Self	Family	Relationship to you		Self	Family	Relationship to you
AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	_____	EYE CONDITIONS:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____	Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis-type _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cancer of eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Color Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	_____	Crossed eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	_____	Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Convulsions / Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____	Lazy eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	_____	Night Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dry Throat / Mouth	<input type="checkbox"/>	<input type="checkbox"/>	_____	Optic nerve problem	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____	Retinal problem	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart condition	<input type="checkbox"/>	<input type="checkbox"/>	_____	Do you use sun protection for your eyes? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Are you pregnant? (females only) <input type="checkbox"/> Yes <input type="checkbox"/> No Due Date _____			
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No How much _____			
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____	Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No How often _____			
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Do you use recreation drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____			
Lung disease / Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Do you drive? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, do you have visual difficulty when driving? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	_____	Date of last eye exam: _____ From Dr. _____			
Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____	Age of glasses: _____			
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	_____	Do you use a computer? <input type="checkbox"/> Yes <input type="checkbox"/> No Hours per day _____			
Skin conditions	<input type="checkbox"/>	<input type="checkbox"/>	_____	Do you wear contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No How old? _____			
Stroke/paralysis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Type? <input type="checkbox"/> disposable <input type="checkbox"/> RGP <input type="checkbox"/> soft <input type="checkbox"/> toric Hours per day _____			
Thyroid condition	<input type="checkbox"/>	<input type="checkbox"/>	_____	Solution type _____			

EYE PROBLEMS: Please check those visual symptoms that you have experienced recently:

<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Eye Strain	<input type="checkbox"/> Loss of vision
<input type="checkbox"/> Burning eyes	<input type="checkbox"/> Floaters or Spots	<input type="checkbox"/> Pain
<input type="checkbox"/> Discharge	<input type="checkbox"/> Foreign body sensation	<input type="checkbox"/> Redness
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Glare	<input type="checkbox"/> Seeing Flashes
<input type="checkbox"/> Double Vision	<input type="checkbox"/> Headaches	<input type="checkbox"/> Tearing
<input type="checkbox"/> Dry eyes	<input type="checkbox"/> Itching	<input type="checkbox"/> Tired Eyes

MEDICATIONS: List current medications, including eye drops.	ALLERGIES: List allergies to medications or other substances
_____	_____
_____	_____

Primary Care Physician name _____ Date of last physical _____

AUTHORIZATION:

I, the undersigned certify that I (or my dependent) have insurance with the above named Insurance company and assign direct to the attending Doctor of Optometry all the insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature: _____ **Relationship:** _____ **Date:** _____