

Date: _____

Name: _____

Address: _____

City, St: _____ Zip: _____

Phone(H): _____ (W): _____

Birthday: _____ Sex: _____

E-Mail: _____

Insurance: _____ Number: _____

Insured: _____ Rel: _____

Secondary: _____ Number: _____

Insured-2: _____ Rel: _____

Medical Doctor(s): _____

Have you ever worn

- No Glasses Gas Perm
- Bifocal Hard
- Trifocals Monovision
- No-line Disposable
- Soft Contacts Overnight
- Toric Soft

Approx. Date of Last Eye Exam: _____

Occupation: _____

Medications (including oral contraceptives, aspirin, over the counter medications and remedies)

No _____

Did you get a flu shot this year? Yes No

Our office requires payment at the time of service unless we "accept assignment" on your insurance. **You are responsible if your insurance doesn't pay.** I understand that my insurance carrier may not cover some services and benefit information does not constitute approval of payment. Deductibles and Fees not paid by my insurance carrier will be my responsibility. Should collection become necessary, I further agree to pay \$2.00 every two weeks on balances over 60 days old. **Contact lens fit and follow up care is billed separately from your eye exam.** Your information is protected by our privacy policy.

Signature: _____ Date: _____

Social History

- Computer Golf Drug Abuse
- Reading Fishing Alcohol Abuse
- Student Tennis No alcohol or drug abuse
- Music Swim Other...
- Skiing Bike

Family History (parents, grandparents, siblings)

- Blindness Diabetes II High B.P.
- Cancer Kidney Thyroid
- Crossed Eyes Macular Degen. Glaucoma
- Color Blind Retina Detach None
- Diabetes 1 Heart Disease Other...

Medical History

Do you currently, or have you ever had problems in the following areas:

Constitutional: No Fever Weight Loss Pregnant/Nursing

Integumentary: No Skin

Neurological: No Headache Migraine

Endocrine: No Thyroid Other Glands

Ears, Nose, Hay Fever

Throat, Mouth: No Sinusitis

Dry Mouth

Respiratory: No Asthma Bronchitis Emphysema

Vascular, Cardiac: No Diabetes 1 Heart

Diabetes 2 High B.P.

Gastrointestinal: No Diarrhea Constipation

Genitourinary: No Genitals/ Kidney/ Bladder

Musculoskeletal: No Arthritis Muscle Pain

Lymph/Hematologic: No Anemia Bleeding Problems

Psychiatric: No Psychiatric

Allergies: No Penicillin Eye drops Codeine

Sulfa Novocaine

Other: _____

Eyes

- Loss of Vision Eye Pain or Soreness Other...
- Blurred Vision Chronic Eye Infection
- Distorted Vision/Halos Sties or Chalazion
- Loss of Side Vision Flashes/ Floaters
- Double Vision Tired Eyes
- Dryness Crossed Eyes
- Mucous Discharge Lazy Eye
- Redness Drooping Eyelid
- Sandy or Gritty Feeling Prominent Eyes
- Itching Glaucoma
- Burning Retinal Disease
- Foreign Body Sensation Cataracts
- Excess Tearing/ Watering Eye Infections
- Glare/ Light Sensitivity Eye Injury

Injuries / Surgeries / Hospitalizations

- LASIK Surg.
- Cataract Surg.
- Retina Surg.
- Other