PLEASE PRINT CLEARLY: Date:___________________________

Patient name:____Occupation:___________________________

Address:____ ZipCode:_________

Date of Birth:_________________Home/Cell #:_________________________Work/Cell#:____________________

E- Mail:____Referred By:____________________________________

- Do you have **VISION** insurance? Y or N (if NO please sign at the bottom and return to desk)

Primary Insurance Company:____ Last 4 of Insured SSN:_________

Policy Holder Name:_______________________________Relationship to Patient:(Self)(Spouse)(Parent)___

Policy or Identification Number:_______________________________________Group Number: ______________

Policy Holder Date of Birth:________________________Employer's Name:________________________________

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- Is there a Secondary or **MEDICAL** Insurance Plan? Y or N

Insurance Company:____ (Secondary) or (Medical)

Address/City/State Zip:____

Policy Number: ____Group Number: _________________________

I authorize the release of medical records to process this claim and payment to the undersigned

Provider: Yes_______________ No___________ Signature____

I agree to pay for the additional charges that my insurance plan does not cover for professional services and glasses or contact lens purchases.

Signed:____Date:_______________________

Privacy Practices Acknowledgement

I have received the notice of privacy practices and I have been provided an opportunity to review it (*Please see Attached*)

Name (if not the Patient):___________________________________Date of Birth:_________________

Signature:____Date:_________________________

Reason For Visit:____ **Last Eye Exam:**____________

Present Eye/Vision Conditions: (Please circle all that apply) **Location:** Both Eyes, Rt. Eye, Left Eye

Quality: Bothersome, Awareness, Painful **Severity:** Severe, mild, moderate **Duration:**_____________ **Timing:** new condition, previous or ongoing **Context:** assoc. with injury, infection, surgery, or medical condition **Mod Factors:** Treated by another provider, Taking medication, Taking drops **Assoc Signs:** Tearing, Double Vision, Pain, Loss of vision, Photophobia, Itching, Headache, Flashes, Burning, Red, Floaters, Blurred Vision

ARE YOU INTERESTED IN TRYING CONTACTS OR DISCUSSING YOUR CONTACT LENS OPTIONS? **Y** **N**

Review of Systems: **Family Physician:** _________________________________

Medical Condition:	**Current Medications:**
1)____________________________	1)____________________________
2)____________________________	2)____________________________
3)____________________________	3)____________________________
4)____________________________	4)____________________________
5) ____________________________	**5)**____________________________
6)____________________________	**6)**____________________________

Medication Allergies: ____________________________ **Environmental Allergies:** __________________________

Ocular History:

	Self	Family Member		Self	Family Member
Macular Degeneration	_____	___________	Cataract	_____	___________
Glaucoma/Glauc. Suspect	_____	___________	Amblyopia/Lazy Eye	_____	___________
Retinal Detachment	_____	___________	Dry Eyes	_____	___________
Eye Surgery:_______________	_____	___________	Other: _________________________________		

Social History: **Smoking Habits:** **Y** **N** **Drinking Habits:** **Y** **N**

Additional Comments: ____

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