Welcome To Our Office

PATIENT INFORMATION

Name:_____
Patient's Last Name First Name MI

Prefer to be called:_____ Social Security #:_____
Mailing Address:_____ Email address:_____
Street Address:_____
City:_____ State:_____ Zip:_____
Home Phone:_____Cell Phone:_____ Office Phone:_____
Preferred to be contacted by: Home_____Cell_____Work_____Email_____please check all that apply
Race: American Indian___ Asian____African American____White____Hispanic or Latino_____Other_____
Date of Birth:_____ Age:_____ Marital Status:_____
Occupation:_____ Employer:_____ Date of Last Exam:_____
FamilyDoctor:_____City_____ Phone_____
Vision Insurance:_____ Primary Health Insurance Provider:_____
If married, give name of spouse:_____
If under 18, please give parents name:_____
Emergency Contact:_____ Phone:_____
Name of other family members who are patients at this office:_____
_____
Who may we thank for referring you to us?_____
Do you use tobacco?_____ Alcohol?_____ Other substances?_____
Are you pregnant?_____
Are you allergic to any medications?_____
Reason for visit or any problems you are having with your vision, glasses or contacts:_____
_____
Are you interested in Glasses_____Contact Lens_____or Both_____

FAMILY HISTORY

High Blood Pressure? Y/N Relation?_____ Macular degeneration? Y/N Relation?_____
Diabetes? Y/N Relation?_____ Retinal detachment? Y/N Relation?_____
Glaucoma? Y/N Relation?_____ Cataracts? Y/N Relation?_____
Other eye conditions? Y/N What kind?_____Relation?_____

ALL PROFESSIONAL SERVICES ARE PAYABLE AT THE TIME OF VISIT.

How will you be paying? ___Cash ___Check ___VISA/MasterCard ___Insurance

Glasses and contact lenses require a 50% deposit when ordering.

Signature of Patient or responsible person:_____ Date:_____

INSURANCE PATIENTS PLEASE SIGN BELOW

PATIENTS OR AUTHORIZED PERON'S SIGNATURE.
I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED_____ DATE_____

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE.
I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED_____ DATE_____

OVER