

PATIENT INFORMATION DATE _____
(PLEASE PRINT)

PATIENT NAME _____ M _____ F _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE # _____ CELL PHONE # _____

DATE OF BIRTH _____ SOCIAL SECURITY# _____ AGE _____

EMPLOYER/OCCUPATION _____ WORK # _____

INSURANCE INFORMATION

INSURANCE COMPANY _____ PATIENT RELATIONSHIP TO INSURED _____

MEMBER # _____ GROUP # _____ INSURED'S NAME _____

INSURED'S DATE OF BIRTH _____ INSURED'S SOCIAL SECURITY _____

**** PLEASE NOTE:
CO-PAYMENTS ARE DUE WHEN SERVICES ARE RENDERED. WE WILL GLADLY SUBMIT CLAIMS TO YOUR INSURANCE COMPANY IF YOU PROVIDE THE PROPER INSURANCE INFORMATION. WE DO NOT GUARANTEE THAT YOUR INSURANCE WILL PROCESS PAYMENT FOR SERVICES. A DEPOSIT IS REQUIRED FOR GLASSES AND OR CONTACT LENSES WHEN THEY ARE ORDERED.**

SIGNATURE OF PERSON RESPONSIBLE FOR PAYMENT

IT IS THE POLICY OF THIS OFFICE THAT THE PARENT WHO REQUESTS TREATMENT FOR A CHILD IS RESPONSIBLE FOR ALL FEES FOR SERVICES RENDERED. (PLEASE SIGN ABOVE)

DATE OF LAST EXAM _____ REASON FOR VISIT _____
FOR TODAY'S VISIT _____

DO YOU FEEL A CHANGE IS NEEDED IN YOUR PRESCRIPTION TO SEE CLEARLY:
AT A DISTANCE _____ Y _____ N NEAR _____ Y _____ N

GENERAL HEALTH - PAST OR PRESENT
____ ALLERGIES _____ DRUG SENSITIVITY _____ EYE SURGERY
____ ASTHMA _____ HIGH BLOOD PRESSURE _____ EYE/HEAD INJURY
____ DIABETES _____ SKIN CONDITIONS _____ GLAUCOMA
____ FAINTING _____ SURGICAL OPERATIONS _____ HEADACHES
____ HAY FEVER _____ EYE DISEASE

FAMILY HISTORY: HAS ANYONE IN YOUR FAMILY HAD ANY OF THE FOLLOWING?:
____ BLINDNESS _____ EYE DISEASE _____ TO WEAR GLASSES
____ DIABETES _____ HEART DISEASE _____ TUBERCULOSIS

LIST ANY CURRENT MEDICATIONS: _____

DATE OF LAST MEDICAL EXAM _____ PHYSICIAN _____
RESULTS _____

HAVE YOU EVER WORN CONTACT LENSES? _____ ARE YOU WEARING THEM NOW? _____ ARE YOU INTERESTED IN WEARING THEM? _____