Welcome to Our Office

For faster service, please complete the following form prior to arriving at our office.

Appointment Date ___________________________

Patient's Name (please print) _______________________________________ M or F (circle one)

If a Child, Parent's Name ____

Street Address ____

City ____________________________ State ___________ Zip Code _____________________

Preferred Phone (circle one) Cell / Home / Work Cell Phone ____________________________

Home Phone _________________________ Work Phone ____________________________

E-mail Address ____

Birth Date ________________

Employer ______________________ Occupation ___________________________________

Spouse's Employer _____________________

Vision Insurance Carrier____________________________ Policy # _____________________

Primary on plan (circle one) self / parent / spouse or domestic partner

Name _________________________DOB____________________

Medical Insurance Carrier ____________________________Policy # ____________________

Primary on plan (circle one) self / parent / spouse or domestic partner

Name _________________________DOB____________________

Secondary Insurance Carrier(s) ____

How did you find out about our office? ____

If internet, what site or search engine?____________________

I authorize the release of any medical information necessary to provide the most beneficial and complete visual examination. I understand that I am financially responsible for all charges whether or not paid by insurance. Payment is due at the time services are rendered.

Signature _____________________________________ Date ________________________

NEED REDO

PATIENT HISTORY QUESTIONNAIRE

Today's Date: ____________________

IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer all questions.

Last Name ____________________ First Name ____________________ MI __________
Address ____________________ City __________ State __________ Zip__________
Work Phone ____________________ Home Phone ____________________
Date of birth ____________________ Occupation____________________ Employer ______
Emergency Contact Name ____________________ Phone Number ____________________ ______
Date of Last Eye Exam ____________________ Dilated? Yes / No Referred By: ____________________
Primary Vision Coverage ____________________ Secondary Coverage ____________________

Medical Information

What is your general health? ____________________

Do you have problems with any of these systems? **(Please circle yes or no.)**

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine (glands)	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/Lymph	Yes/No
Cardiovascular	Yes/No	Muscles/Bones	Yes/No	Allergic/Immunologic	Yes/No
Respiratory	Yes/No	Integumentary (skin)	Yes/No	Headaches	Yes/No
High Blood Pressure	Yes/No	Eyes	Yes/No	Mental	Yes/No

Please explain ____________________
Diabetes Yes/No Type ____________________ Date of diagnosis____________________
Allergies to Medication Yes/No Which?____________________Reactions? ____________________
Other health probems ____________________
Current medication(s) ____________________
Have you had any operations? Yes/No Kind? ____________________When? ____________________
Name of family doctor ____________________
Date of last visit ____________________ Date of last tetanus shot ____________________

Family History

High blood pressure	Yes/No	Relation __________	Macular degeneration	Yes/No	Relation	__________
Diabetes	Yes/No	Relation __________	Retinal detachment___	Yes/No	Relation	__________
Glaucoma	Yes/No	Relation __________	Cataracts __________	Yes/No	Relation	__________

Personal Eye Information

Do you have any eye conditions or problems? Yes/No What kind? ____________________
Have you had any eye operations? Yes/No Type ____________________ Date __________
Have you had an eye injury? Yes/No Kind ____________________ Date __________

Do you have glaucoma?	Yes/No	Cataracts?	Yes/No	Dry eyes?	Yes/No
Macular degeneration?	Yes/No	Retinal detachment?	Yes/No	Blurred vision?	Yes/No
Do you wear glasses?	Yes/No	Contact lenses?	Yes/No	Type ____________________	

Additional information ____________________

Doctor Use Only

Reviewed by ____________________ ❍ No changes Date ____________________
Reviewed by ____________________ ❍ No changes Date ____________________