PATIENT INFORMATION

LAST NAME	FIRST NAME	INIT.	Choose one: Mr/Mrs/Ms/Dr	BIRTHDATE	AGE

STREET ADDRESS CITY ZIP CODE	HOME PHONE
EMPLOYER NAME AND ADDRESS	WORK PHONE
YOUR OCCUPATION	CELL PHONE
VISION INSURANCE PLAN	INSURANCE ID NUMBER
EMAIL ADDRESS	How Did You Hear About Us?

When was your last eye examination?_____ Doctor's name_____
Please list a few of your
favorite hobbies or sports:_____
Are any family members patients of this office? If so, who?_____

Do you or a family member (F)
Have any of the following:
(Please check)

me	(F)	
___	___	Glaucoma
___	___	Diabetes
___	___	Cataracts
___	___	Eye injury or surgery
___	___	Macular Degeneration
___	___	High Blood Pressure
___	___	Other_____

Current Medication(s)_____
_____

Medication Allergies_____

Do you use cigarettes/tobacco? Y/N
Alcohol? Y/N Other Substances? Y/N

Are you currently wearing contact
lenses? Y/N What type?_____

What solutions do you use?_____

The doctor may need to dilate your eyes today. If so, the doctor will explain why dilation is necessary prior to putting the drops in your eyes.
Do you consent to having your eyes dilated if necessary? ____yes ____no

Our office requests that professional services be paid for at the time they are rendered. A deposit of at least half the cost of the materials on order date is customary, the balance due on dispensing.
A five dollar per month ($5.00) surcharge will be applied to all accounts with outstanding balances greater than sixty days.
If your insurance denies payment for any reason, you are responsible for the unpaid balance.

ID#_____

LAST FOUR DIGITS OF SSN#	SIGNATURE	DATE