## Personal Information

Mr. Mrs. Ms. Dr. Rev. _____ Gender M F Date _____

Street Address _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Cell/Alt # _____ Date of Birth _____ Age _____

Social Security # _____ Occupation _____ Name of Parent/Spouse _____

Hobbies / Sports _____ Email Address _____

I have been provided with a copy of the HIPAA privacy policy to read. _____
Signature of Patient / Guardian Date

## Insurance Information (Major Medical)

**Financially responsible party:** _____

Insurance Co _____ Member # _____ Group # _____

Primary Insured's Name _____ Insured's DOB _____ Insured's SS# _____

Address _____ Insured's Employer: _____

## Insurance Information (Vision or Secondary)

Insurance Co _____ Member # _____ Group # _____

Primary Insured's Name _____ Insured's DOB _____ Insured's SS# _____

Address _____ Insured's Employer: _____

## Medical and Ocular History

Do you wear Contact Lenses? **Y** **N** Brand? _____ Are you interested in contact lenses? **Y** **N** Do you wear glasses? **Y** **N**

When was your last eye exam? _____ Where was it? _____ Doctor? _____

Do you work at a computer terminal? **Y** **N** How many hours per day? _____ Are you interested in refractive surgery? **Y** **N**

Do you or any family member have a history of the following:

| | NO | YES Self | YES Family | | NO | YES Self | YES Family |
|---|---|---|---|---|---|---|---|
| **Eyes** | | | | **Eyes Cont:** | | | |
| Blindness | ☐ | ☐ | ☐ | Glaucoma | ☐ | ☐ | ☐ |
| Blurred vision | ☐ | ☐ | ☐ | Halos | ☐ | ☐ | ☐ |
| Burning/Itching | ☐ | ☐ | ☐ | Loss of vision | ☐ | ☐ | ☐ |
| Cataracts | ☐ | ☐ | ☐ | Macular Degeneration | ☐ | ☐ | ☐ |
| Chronic eye infections | ☐ | ☐ | ☐ | Mucous discharge | ☐ | ☐ | ☐ |
| Crossed eyes | ☐ | ☐ | ☐ | Red eyes | ☐ | ☐ | ☐ |
| Double Vision | ☐ | ☐ | ☐ | Retinal detachment | ☐ | ☐ | ☐ |
| Dry eyes | ☐ | ☐ | ☐ | Retinal Problems | ☐ | ☐ | ☐ |
| Excessive Tearing | ☐ | ☐ | ☐ | **Other** | | | |
| Eye Allergies | ☐ | ☐ | ☐ | Cancer | ☐ | ☐ | ☐ |
| Eye Pain/Soreness | ☐ | ☐ | ☐ | Diabetes | ☐ | ☐ | ☐ |
| Eye Surgery | ☐ | ☐ | ☐ | Headaches | ☐ | ☐ | ☐ |
| Flashes/Floaters | ☐ | ☐ | ☐ | Heart Diseases | ☐ | ☐ | ☐ |
| Glare/Light sensitivity | ☐ | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | ☐ |

List any medications you are currently taking:

List your Past Ocular History and General Medical History (illness, surgery, injuries, treatments):

**Comments on any Medical Condition:**

**Allergies** Y N Explain:

## Medical History Required by your Insurance Company

| | NO | YES Self | YES Family | | NO | YES Self | YES Family | | NO | YES Self | YES Family |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Musculoskeletal** | | | | **Respiratory** | | | | **Gastrointestinal** | | | |
| Arthritis | ☐ | ☐ | ☐ | Chronic Bronchitis | ☐ | ☐ | ☐ | Ulcers | ☐ | ☐ | ☐ |
| Joint pain | ☐ | ☐ | ☐ | Emphysema | ☐ | ☐ | ☐ | Other | ☐ | ☐ | ☐ |
| **Neurological** | | | | **Hematologic/Lymphatic** | | | | **Ears, Nose, Mouth, Throat** | | | |
| Seizures | ☐ | ☐ | ☐ | Anemia | ☐ | ☐ | ☐ | Sinus problems | ☐ | ☐ | ☐ |
| Other | ☐ | ☐ | ☐ | Bleeding Problems | ☐ | ☐ | ☐ | Chronic cough | ☐ | ☐ | ☐ |
| **Genitourinary** | | | | Swelling | ☐ | ☐ | ☐ | Dry mouth/Throat | ☐ | ☐ | ☐ |
| Kidneys | ☐ | ☐ | ☐ | **Cardiovascular** | | | | Chronic ear infections | ☐ | ☐ | ☐ |
| Bladder | ☐ | ☐ | ☐ | Heart Problems | ☐ | ☐ | ☐ | **Allergic/Immunologic** | | | |
| **Constitutional** | | | | Vascular disease | ☐ | ☐ | ☐ | Hay Fever | ☐ | ☐ | ☐ |
| Fever | ☐ | ☐ | ☐ | **Endocrine** | | | | Medicine Allergies | ☐ | ☐ | ☐ |
| Weight loss | ☐ | ☐ | ☐ | Thyroid problems | ☐ | ☐ | ☐ | Systemic Allergies | ☐ | ☐ | ☐ |
| Weight gain | ☐ | ☐ | ☐ | Other glands | ☐ | ☐ | ☐ | **Psychiatric** | ☐ | ☐ | ☐ |

Have you ever been exposed to or infected with:

| | | |
|---|---|---|
| Gonorrhea | **Y** | **N** |
| Hepatitis | **Y** | **N** |
| HIV | **Y** | **N** |
| Syphilis | **Y** | **N** |
| Chlamydia | **Y** | **N** |

**Comments on any Medical Condition:**

Do you use tobacco products? **Y** **N** If yes, type, amount and how long? _____

Do you drink alcohol? **Y** **N** If yes, type, amount and how long? _____

Your insurance is meant to serve as a financial aid. We are happy to take assignment on your benefits. If you are not eligible for these benefits or are eligible for less than full coverage, **your signature indicates that you agree to be financially responsible for the balance not paid by your plan**. (Contact lens wearers- Rarely will insurance plans cover the entire exam, contact lenses, and professional fees for contact lens evaluations. Our office staff will make every effort to verify your benefits). **VERIFICATION OF BENEFITS IS NOT A GUARANTEE OF PAYMENT.**

Signature: _____ Date: _____

**Must be signed by Parent/Guardian if the patient is under 18 years of age.**