

Patient Information (Please Print)

First name middle initial Last name Birthdate SS#

Address Apt# City State Zip

Home phone work phone cell phone Email

Sex: Male / Female (circle one) Marital status: single / married / widowed / divorced (circle one)

Employer Occupation

Emergency Contact Relationship Phone#

Person responsible for bill (if minor) Date of Birth Relationship

How did you hear about our practice? _____

1) Insurance Co. _____ ID# _____ Policyholder _____ Rel. _____ Birthdate _____
2) Insurance Co. _____ ID# _____ Policyholder _____ Rel. _____ Birthdate _____

Allergies _____ Medical Dr. _____
(first and last name)

Medical conditions _____

Current medications _____

Past Medical Surgeries _____

Family hx: Diabetes / Cancer / Blood Pressure / Glaucoma / Cataracts / Thyroid / Retinal problems (please circle)

Do you wear: Eyeglasses / Contacts How many years? _____

Past eye surgeries/injuries/infections _____

Reason for exam _____ last eye exam _____

Is this related to an on-the-job injury or auto accident? _____

Workman's comp. information (if applicable) _____

AUTHORIZATIONS

I understand that it is my responsibility to pay any deductibles, copays, coinsurance or other balances not paid by my insurance including glasses, contact lenses, contact lens fittings or routine examinations. I understand that I may be asked to make a copay at every visit. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services. I also acknowledge that a Privacy Notice is available to me upon my request.

Date: _____ Signature _____