Name______________________________ Date of Birth________________________

Spouse/Parent______________________ Age___Male__ Female__Eye Color____

Address____________________________ Phone Number_____________________

___________________________________ Work Number______________________

Occupation_________________________ Cell Number ______________________

Social Security Number_____-___-______ E-mail ____________________________

Vision Insurance______________________ Medical Insurance_________________

Medical Physician______________________________________

PAST OCULAR HISTORY

Date of Last Eye Exam__________________ Date of Last Pair of Glasses__________
History of Eye Trauma____
History of Eye Surgery____

Eye Diseases (Glaucoma, Cataracts, Retinal Detachment, Macular Degeneration)
Please list any that apply:

Do you have dry eyes? Yes/No Blurred vision? Yes/No
*Are you interested in Laser Vision Correction? Yes_________ No_________

PAST AND PRESENT MEDICAL HISTORY

Medication Allergies___________________ Environmental Allergies________________
Current Medications____
Previous Surgeries____
Eye Medications____

MEDICAL CONDITIONS (PATIENT)

	Yes	No		Yes	No
Thyroid disease	___	___	Respiratory	___	___
Blindness	___	___	Fever/Weight Loss	___	___
Heart Disease	___	___	Muscle/Bone/Joint	___	___
Diabetes	___	___	Blood/Bleeding Disorder	___	___
Kidney	___	___	Liver	___	___
Hepatitis	___	___	Abdominal Problems	___	___
High Blood Pressure	___	___	Genital / Urinary	___	___
Nervous Disorder	___	___	Ear/Nose/Mouth/Throat	___	___
Psychological Disorder	___	___	Cancer	___	___
Cholesterol	___	___			

SOCIAL HISTORY

Smoking ____ ____
Alcohol ____ ____
Drugs ____ ____

FAMILY HISTORY (RELATIVES, ie MOTHER,FATHER,GRANDPARENTS)

	Yes No		Yes No
Glaucoma	____ ____	Heart Disease	____ ____
Cataracts	____ ____	Hypertension	____ ____
Crosses/Lazy Eyes	____ ____	Diabetes	____ ____
Retinal Detachment	____ ____	Blindness	____ ____

MEDICARE, MEDICAID, BLUE CROSS BLUE SHIELD, VSP AND ALL OTHER INSURANCE PATIENTS/NON-INSURANCE PATIENTS:

“ I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Administration (for Medicare patients) or to my insurance company and/or it’s intermediaries, any information needed for related claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to either myself or to the party who accepts assignment.”

In the event of a denial or rejection of this claim by insurance company, I understand that the payment of said claim will be my responsibility.

ALL PATIENTS WITH INSURANCE ARE RESPONSIBLE FOR THE $35.00 REFRACTION FEE IF THAT IS NOT COVERED BY SAID INSURANCES.
I acknowledge that I was offered a copy of the Notice of Privacy Practices.

____ Date_________________
SIGNATURE OF GUARANTOR/PATIENT

I hereby give approval to disclose any or all of my medical information to:

NAME:________________________ RELATIONSHIP________________________

REFERRED BY: ____

For Doctors Use Only: Date_________ Reviewed by_________ No changes________
Date_________ Reviewed by _________ No changes________
Date_________ Reviewed by _________ No changes________